Post-Deployment Health Care in the Primary Care Setting

Nov 04

Presentation Outline

- History of the Post-Deployment Health Clinical Practice Guideline (PDH-CPG)
- Contents of the PDH-CPG
- Implementation Tools for the PDH-CPG

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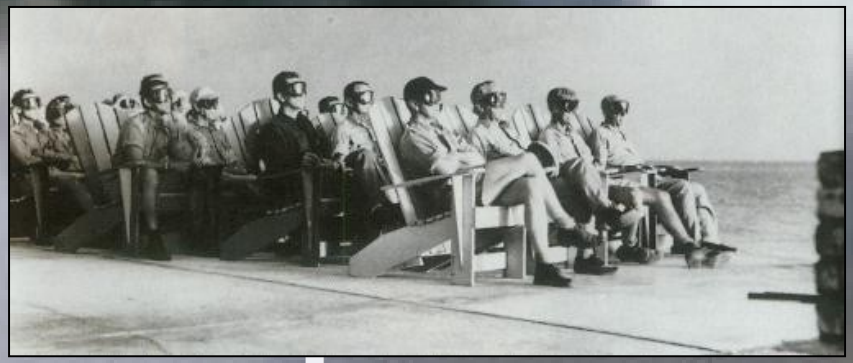
Why Focus On Post-Deployment Health Care?

("Isn't it just 'routine health care' in a slightly different uniform?")



...because our workplace may be hazardous to health.

History Made Overly Simple

Before Vietnam

Life & Limb

t

After Vietnam

Post-Traumatic Stress Disorder

After Gulf War

Toxic Exposure Concerns

Medically Unexplained Symptoms

Gulf War Post-Deployment Health Program

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- Comprehensive Clinical Evaluation Program (CCEP)
  - Initiated in June 1994
  - Standardized, staged evaluation and treatment program to assess possible Gulf War-related conditions
  - Based on the VA Persian Gulf War Health Examination Registry
  - Focused on specialty care

Institute of Medicine Recommendations for Improving PDH Care

- Focus evaluations and care at the **primary care** level to
  - Enhance continuity of care
  - Foster the establishment of **ongoing therapeutic relationships**
- Use an evidence-based approach to develop **clinical practice guidelines** for deployment-related health concerns

Clinical Practice Guideline for Post-Deployment Health

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- DoD/VA **P**ost-**D**eployment **H**ealth Evaluation and Management **C**linical **P**ractice **G**uideline (PDH-CPG)
  - Completed by an expert multi-disciplinary, multi-agency panel in 2001
  - Initiated with a worldwide satellite broadcast January 2002
  - Tool Kit of supporting materials distributed to all military MTFs
  - Replaced CCEP
  - No change since 2002 except modified coding guidance

PDH-CPG Differences from CCEP

CCEP 1994-2002

- Target patient population:
  - Gulf War veterans with symptoms
- Focused on exhaustive medical evaluations for affected veterans
- PDH care provided by specialists
- Registry

PDH-CPG 2002-

- Target population expanded:
  - Active duty, retired, family members
  - Deployed, non-deployed
  - All deployments including homeland
- Clinical Practice Guideline with focus on primary care
- PDH care provided by Primary Care Manager
- Tracking thru coding

PDH-CPG Use Mandated by Health Affairs – April 2002

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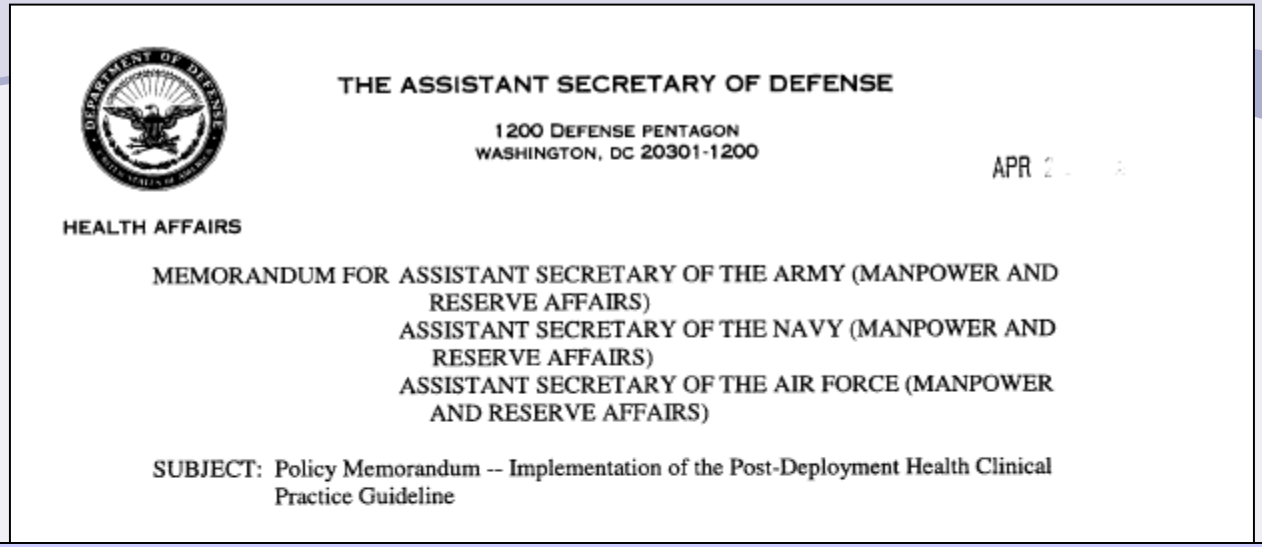

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

APR 2

HEALTH AFFAIRS

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE AIR FORCE (MANPOWER AND RESERVE AFFAIRS)

SUBJECT: Policy Memorandum -- Implementation of the Post-Deployment Health Clinical Practice Guideline

"All DoD military treatment facilities should now be using the Post-Deployment Health Clinical Practice Guideline …the military unique vital sign question '*Is the reason for your visit today related to a deployment?*' should be asked of every patient…providers will review and employ, as needed, this guideline during their evaluations…"

Deployment Health Centers of Excellence

- **Deployment Health Clinical Center**
  at Walter Reed Army Medical Center in Washington, DC
  - *Proponent for PDH-CPG*
- **Deployment Health Research Center**
  at Naval Health Research Center in San Diego, CA
- **Deployment Health Surveillance Center**
  at Army Center for Health Promotion & Preventive Medicine in Aberdeen, MD

Section 743 of the Strom Thurmond National Defense Authorization Act, 1999

National Science and Technology Council Presidential Review Directive 5

(PRD – Planning for the Health Preparedness for and Readjustment of the Military, Veterans, and their Families after Future Deployments

Institute of Medicine, Strategies to Protect the Health of Deployed U.S. Forces, 2000

Presentation Outline

- History of the Post-Deployment Health Clinical Practice Guideline (PDH-CPG)
- Content of the PDH-CPG
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Overview of PDH-CPG Features

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- Military unique **vital sign**
- Clinically-based **risk communication**
- Use of an **algorithm-based stepped care** approach
- Emphasis on longitudinal **follow-up**
- Web-based **clinician support**
- Supporting **Center of Excellence**
- Metrics and outcomes **monitoring**

What Is the Military Unique Vital Sign?

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- All persons should be asked "*Is your health concern today related to a deployment?*" upon visiting any primary care provider for any illness or concern.
- PDH-CPG vital sign for all care contacts except wellness visits (e.g. periodic exams and preventive care)
- Patient rather than provider determination
- Deployment is not necessary to have a deployment-related concern

Role of Medical Screener in PDH Screening Process

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- Role of Medical Screener
  - Asks military unique vital sign: *"Is your health concern today related to a deployment?"*
  - Marks response on stamped or overprinted SF600
  - Alerts provider to "*yes*" or "*maybe*" responses
- Training for Medical Screener
  - How to ask the question
  - How to answer patient questions
  - How to document the answer

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What Is Risk Communication?

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- A science-based approach for communicating effectively in conditions of high concern, low trust and sensitive or controversial situations
- Helps to build rapport between patient and provider
- Improves patient:
  - Adherence to medical advice
  - Trust in healthcare system and satisfaction with care
  - Functioning and health behaviors
- Improves provider satisfaction with process of delivering care

Clinical Risk Communication

E N V I T E

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E-mpathy: Listen actively. Acknowledge patient's concerns. Express concern. Convey genuine desire to assist.

N-on confrontational: Avoid disapproving comments. Don't argue.

V-alidate: Validate the patient's decision to seek care

I-nform: Offer data followed by a short "sound byte" that addresses patient specific concerns.

T-ake Action: Describe options. Order appropriate tests/labs. Schedule a follow-up. Research concerns. Consider consultation or second opinion, as needed.

E-nlist Cooperation: Negotiate an action plan with the patient rather than imposing one.

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Stepped Risk Communication Strategy

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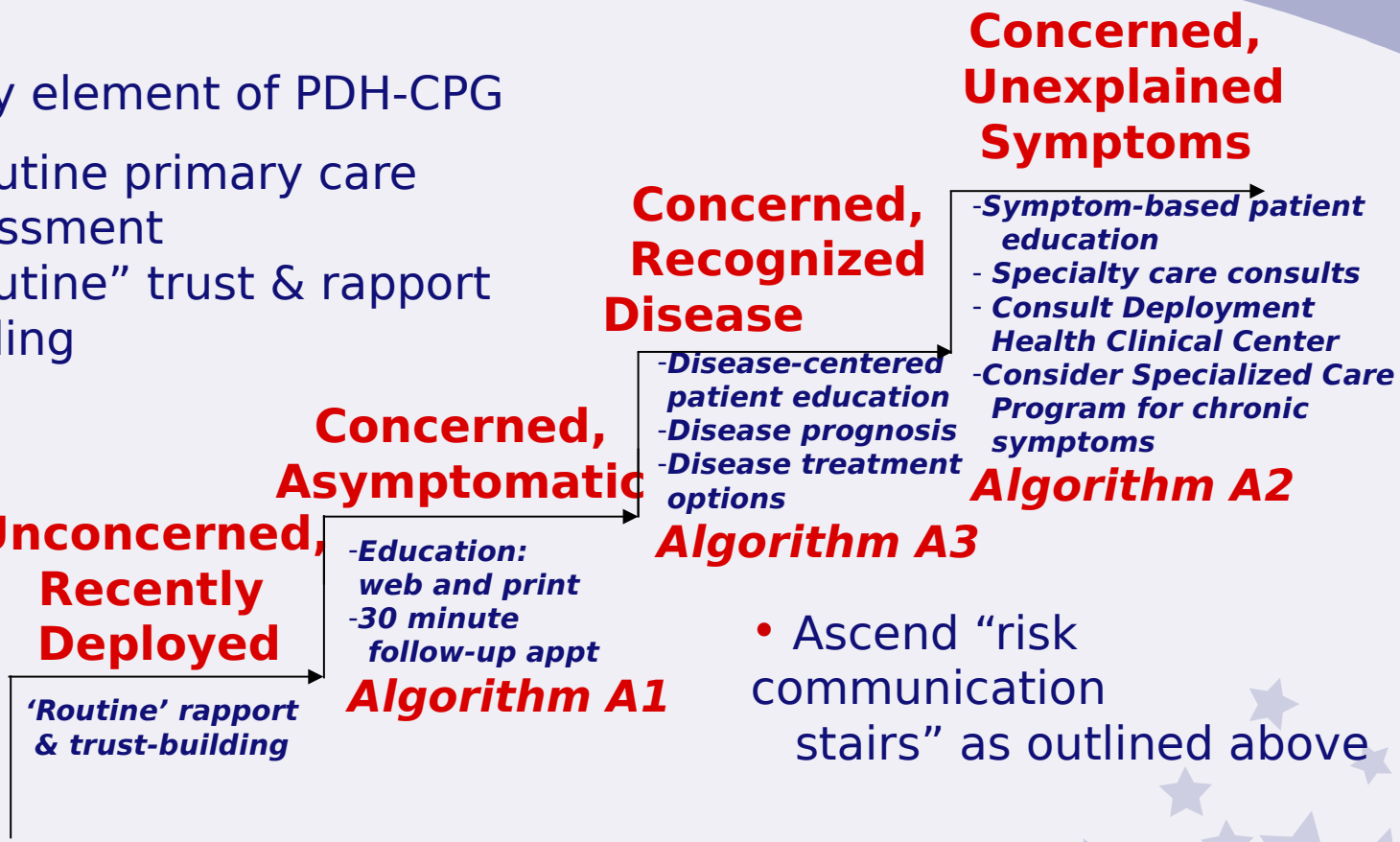
- Key element of PDH-CPG
- Routine primary care assessment
  "routine" trust & rapport building



- Ascend "risk communication stairs" as outlined above

PDH-CPG Process Overview
1st Visit (15 minutes)

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- Identify any PDH concerns
- Establish partnership with patient (Risk communication)
- Initiate clinical evaluation
- Triage patient based on PDH-CPG algorithms and seek to reach a working diagnosis on follow-up visits
  - Asymptomatic Concerned
  - Established Diagnosis
  - Medically Unexplained Symptoms
- Document post-deployment concern in chart and ADM

DD Form 2844 - Post Deployment Medical Assessment Form and Primer

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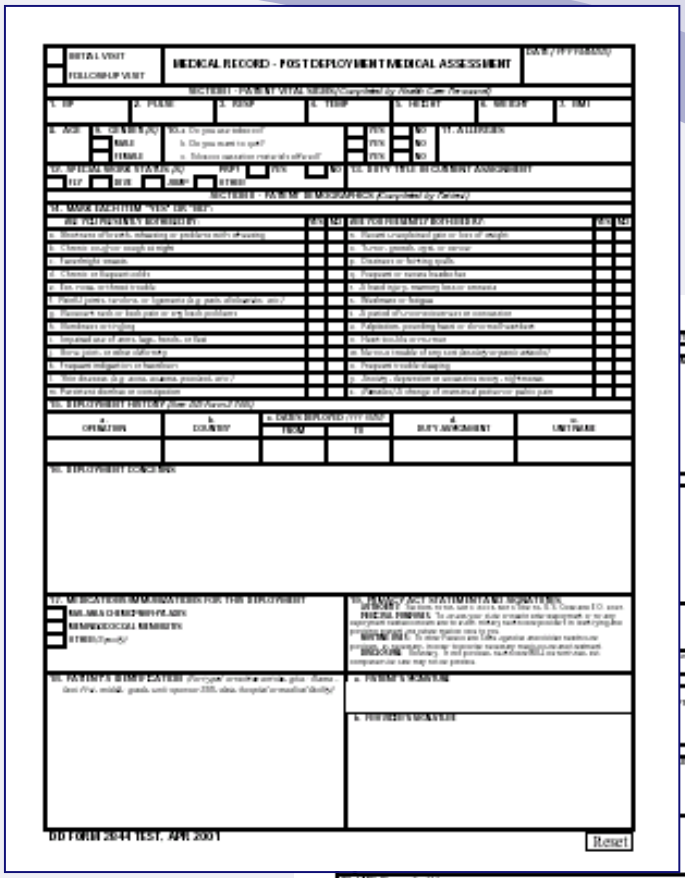
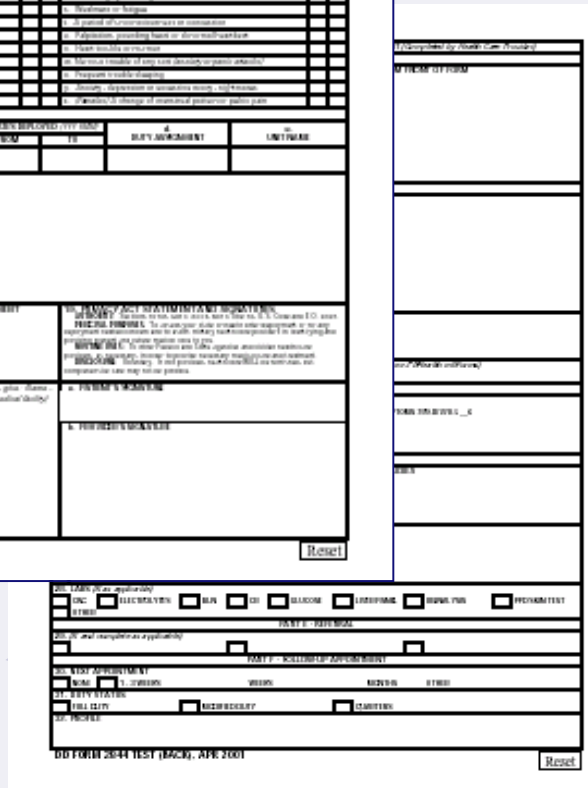
- Optional form in lieu of SF 600 for documenting post-deployment medical evaluation
- Front - patient symptoms deployment history and concerns
- Back - medical history, physical exam, diagnosis, treatment plan, referrals and follow-ups





Researching Deployment-Related Concerns

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- Between 1st & 2nd visit – Research exposure/concern
- Often the patient initially knows more about deployment-specific exposures than the provider
- Identify known risks and potential hazards and exposures for the patient's deployment
- Consult *www.PDHealth.mil*

PDH-CPG Process Overview
Follow-Up Visits

- 2nd visit (30 minutes)
  - Continue evaluation (review ancillary studies, consults and deployment exposure information)
  - If possible, establish diagnosis and start therapy
  - If not, order additional ancillary studies and consults as appropriate
- 3rd visit (30 minutes)
  - Diagnosis established: monitor therapy
  - Diagnosis not established: review additional testing and consultation results
  - Continue with algorithm
  - Consider consulting with DHCC

Ancillary Studies

- Selected ancillary studies should be performed based on clues derived from the history and physical examination
- Testing should be avoided purely for the basis of screening as these tests may
  - Have very low specificity
  - Result in false positive results
  - Cause unrealistic patient expectations

What Should Providers Do at Each Visit?

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- Ask if there are unaddressed or unresolved concerns
- Summarize and explain all test results
- Schedule follow-up visits in a timely manner
- Offer to include the concerned family member or significant other in the follow-up visit
- Utilize other members of health care team to assist in patient education

Asymptomatic Concerned *(Algorithm A1)*

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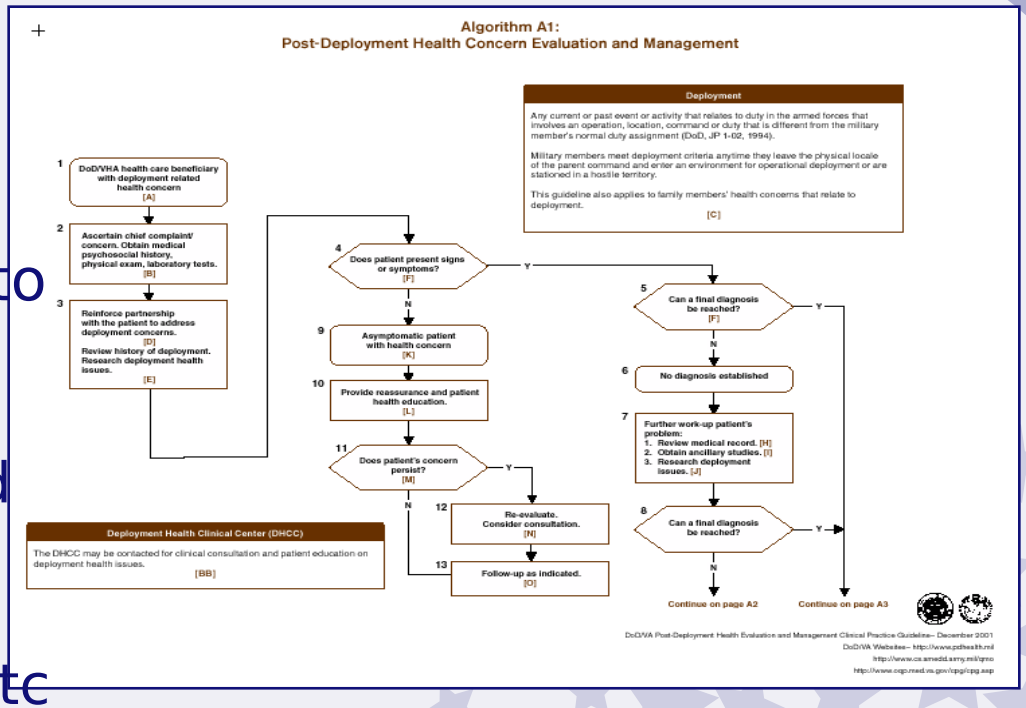
- Expresses a health concern, but does not exhibit or describe any discernable illness or injury
- Concerns may be related to
  - Illness
  - Vaccine or medication
  - Exposure or anticipated exposure
  - An experience
  - News media, Internet,etc



Asymptomatic Concerned
Recommended Management

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- Provide:
  - Clinical risk communication - reassurance
    - Attempt to understand patient's beliefs
    - Establish a collaborative and negotiated understanding as basis for further communication
  - Patient education
  - Preventive care
- Schedule 30 minute follow-up visit
- If concern persists:
  - Re-evaluate
  - Consider consultation
- Document in chart and code v70.5_6 plus v65.5 in ADM

How to Code Post-Deployment Visits

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- **Primary ICD-9-CM code**: **v70.5_ 6**
  - Changed from secondary code position in 2003
  - Definition: "A visit used to evaluate, clarify, treat, or provide information regarding one or more patient or provider based post-deployment health concerns."
  - Does not necessarily establish or imply causality between any of the provider's diagnoses and any particular deployment
  - Used for deployment health concerns and PDHA exams
- **Secondary ICD-9-CM code**: **Diagnosis-specific code**
- **E & M codes** used to differentiate CPG from PDHA visits

Established Diagnosis *(Algorithm A3)*

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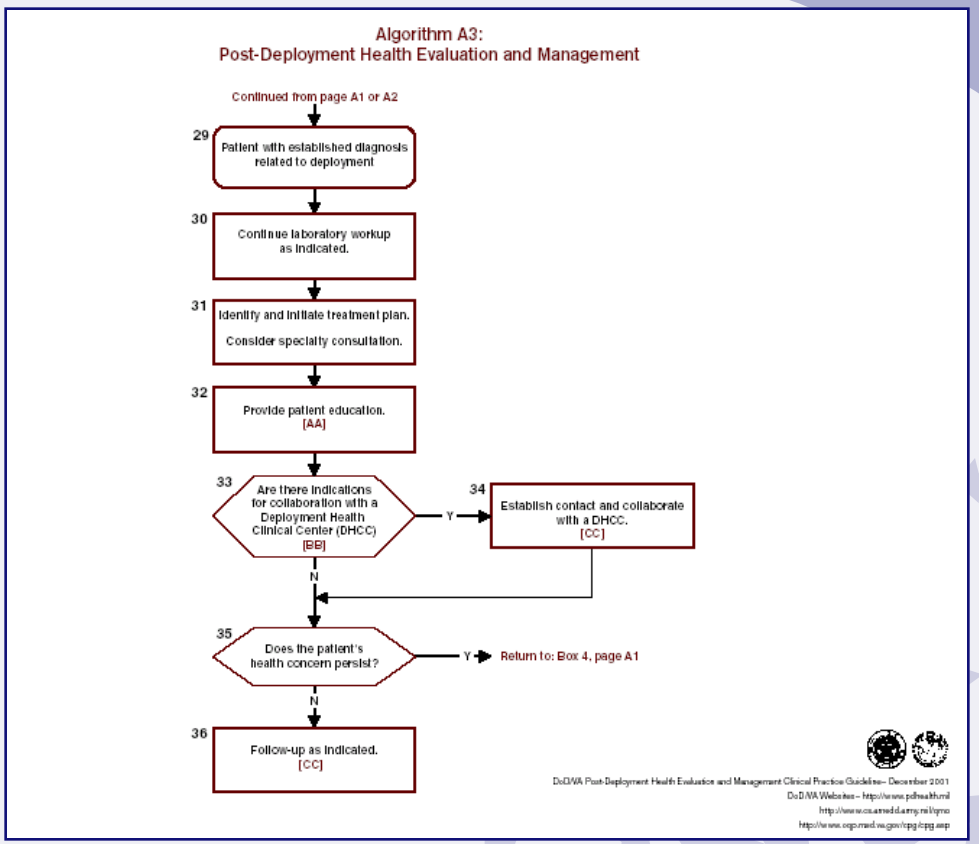
- Clinically defined injury or disease based on objective and reproducible clinical findings on examination, laboratory testing or medical imaging



Established Diagnosis
Recommended Management

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- Identify appropriate disease management guideline
- Initiate appropriate treatment plan
- Provide patient education
- Collaborate with DHCC, if needed
- Follow-up with patient per disease-specific guideline or as appropriate
- Document in chart
- Code in ADM using v70.5_6 plus disease-specific code

Medically Unexplained Symptoms *(Algorithm A2)*

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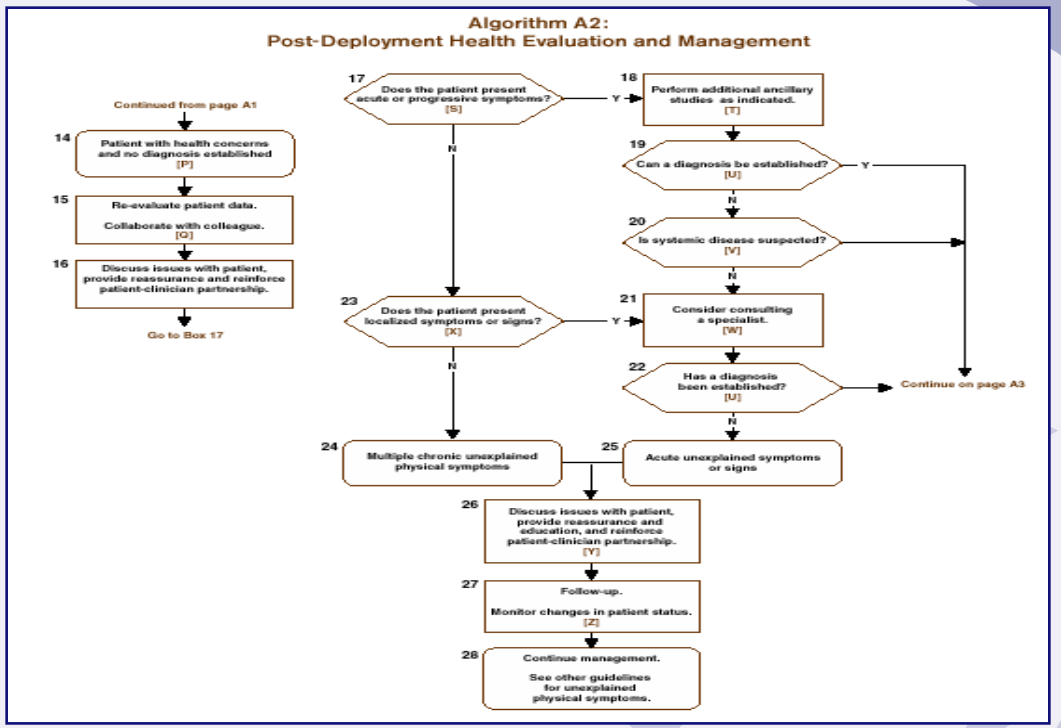
- Symptoms that remain unexplained after an appropriate medical assessment that includes focused diagnostic testing
- Highly recommended that ≥ 2 visits be completed before concluding that the patient does not have a recognizable illness



Medically Unexplained Symptoms
Recommended Management

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- Re-evaluate; consult with colleagues/DHCC
- Reinforce patient-clinician relationship
- Provide patient education
- Refocus patient's attention from symptoms to improving functional status and quality of life
- Emphasize physical and psychological activation and self-management strategies
- Maintain regular follow-up to monitor changes in status
- Involve family or other support systems, when possible
- Document in chart and code v70.5_6 plus 799.8 in ADM

VA/DoD Medically Unexplained Symptoms (MUS) Clinical Practice Guideline

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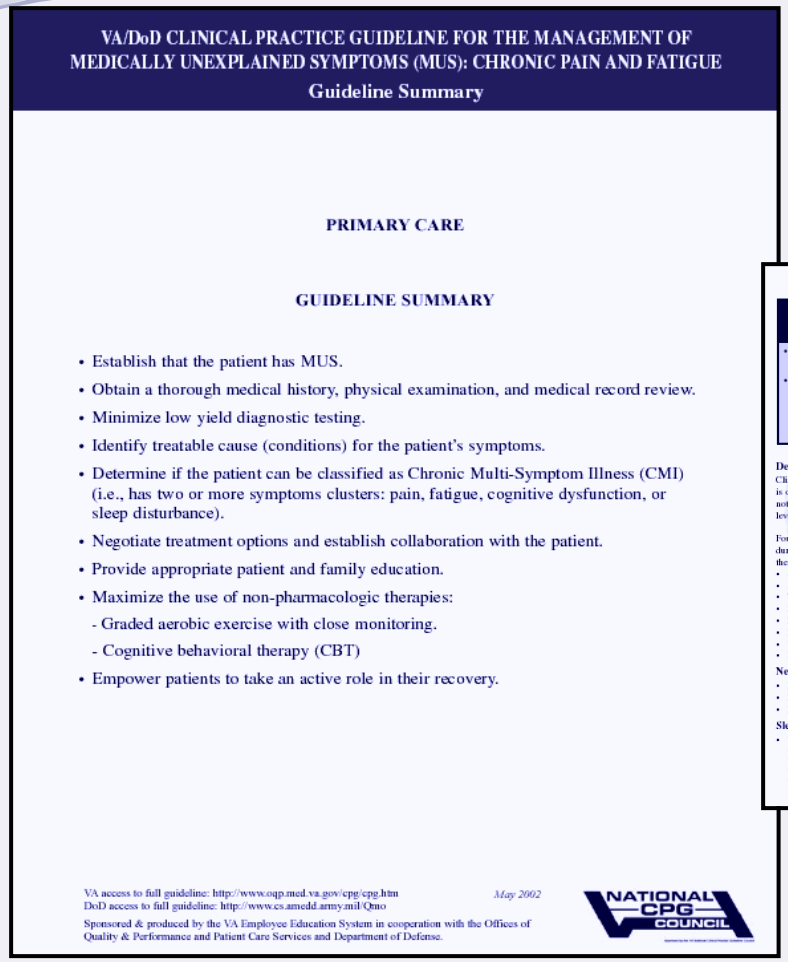


VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF MEDICALLY UNEXPLAINED SYMPTOMS (MUS): CHRONIC PAIN AND FATIGUE

Guideline Summary

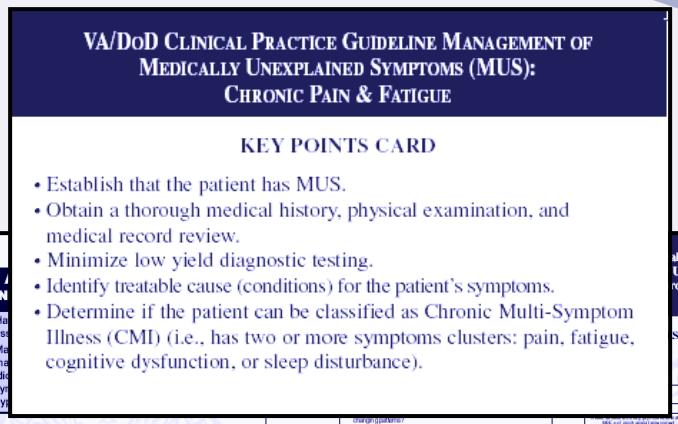
PRIMARY CARE

GUIDELINE SUMMARY

- Establish that the patient has MUS.
- Obtain a thorough medical history, physical examination, and medical record review.
- Minimize low yield diagnostic testing.
- Identify treatable cause (conditions) for the patient's symptoms.
- Determine if the patient can be classified as Chronic Multi-Symptom Illness (CMI) (i.e., has two or more symptoms clusters: pain, fatigue, cognitive dysfunction, or sleep disturbance).
- Negotiate treatment options and establish collaboration with the patient.
- Provide appropriate patient and family education.
- Maximize the use of non-pharmacologic therapies:
  - Graded aerobic exercise with close monitoring.
  - Cognitive behavioral therapy (CBT)
- Empower patients to take an active role in their recovery.

VA access to full guideline: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guideline: http://www.cs.amedd.army.mil/Qmo
May 2002
Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and Patient Care Services and Department of Defense.

NATIONAL CPG COUNCIL



VA/DoD CLINICAL PRACTICE GUIDELINE MANAGEMENT OF MEDICALLY UNEXPLAINED SYMPTOMS (MUS): CHRONIC PAIN & FATIGUE

KEY POINTS CARD

- Establish that the patient has MUS.
- Obtain a thorough medical history, physical examination, and medical record review.
- Minimize low yield diagnostic testing.
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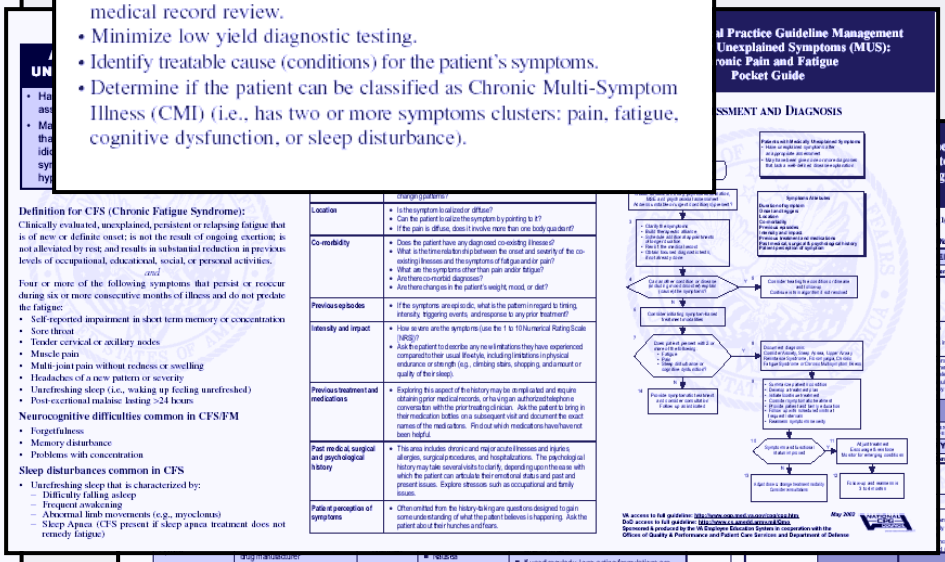

Definition for CFS (Chronic Fatigue Syndrome):
Clinically evaluated, unexplained, persistent or relapsing fatigue that is of new or definite onset; is not the result of ongoing exertion; is not alleviated by rest; and results in substantial reduction in previous levels of occupational, educational, social, or personal activities.
and
Four or more of the following symptoms that persist or reoccur during six or more consecutive months of illness and do not predate the fatigue:
- Self-reported impairment in short term memory or concentration
- Sore throat
- Tender cervical or axillary nodes
- Muscle pain
- Multi-joint pain without redness or swelling
- Headaches of a new pattern or severity
- Unrefreshing sleep (i.e., waking up feeling unrefreshed)
- Post-exertional malaise lasting >24 hours

Neurocognitive difficulties common in CFS/FM
- Forgetfulness
- Memory disturbance
- Problems with concentration

Sleep disturbances common in CFS
- Unrefreshing sleep that is characterized by:
  - Difficulty falling asleep
  - Frequent awakening
  - Abnormal limb movements (e.g., myoclonus)
  - Sleep Apnea (CFS present if sleep apnea treatment does not remedy fatigue)

			■ If used regularly, long-acting formulations are preferred.
S-adenosyl-L-methionine (SAMe)**	■ 200 mg/day subq ■ 400 mg/day IV ■ 800 mg/day orally	Possibly	■ None documented ■ Drug is available in the United States orally, as an over-the-counter dietary supplement.
Sleep: Melatonin**	3 to 6 mg/day	Equivocal	— ■ May help a limited number of patients who have difficulty initiating sleep.

*TRAMADOL - NON-FORMULARY MEDICATION. AVAILABLE BY PHYSICIAN REQUEST USING THE NON-FORMULARY PROCESS.
**SAM-e AND MELATONIN ARE NUTRITIONAL SUPPLEMENTS THAT THE VA DOES NOT PROVIDE. ARE AVAILABLE AS OVER THE COUNTER PRODUCTS.

©NOT EVERY PANEL OF EXPERT GUIDELINE DEVELOPERS HAS REACHED THE SAME CONCLUSIONS REGARDING THE BENEFIT OF DRUGS. SEE "CLINICAL EVIDENCE VOL. 6. DEC. 2001" A PUBLICATION OF THE BRITISH MEDICAL JOURNAL.

Medically Unexplained Symptoms
Patient Education Brochures

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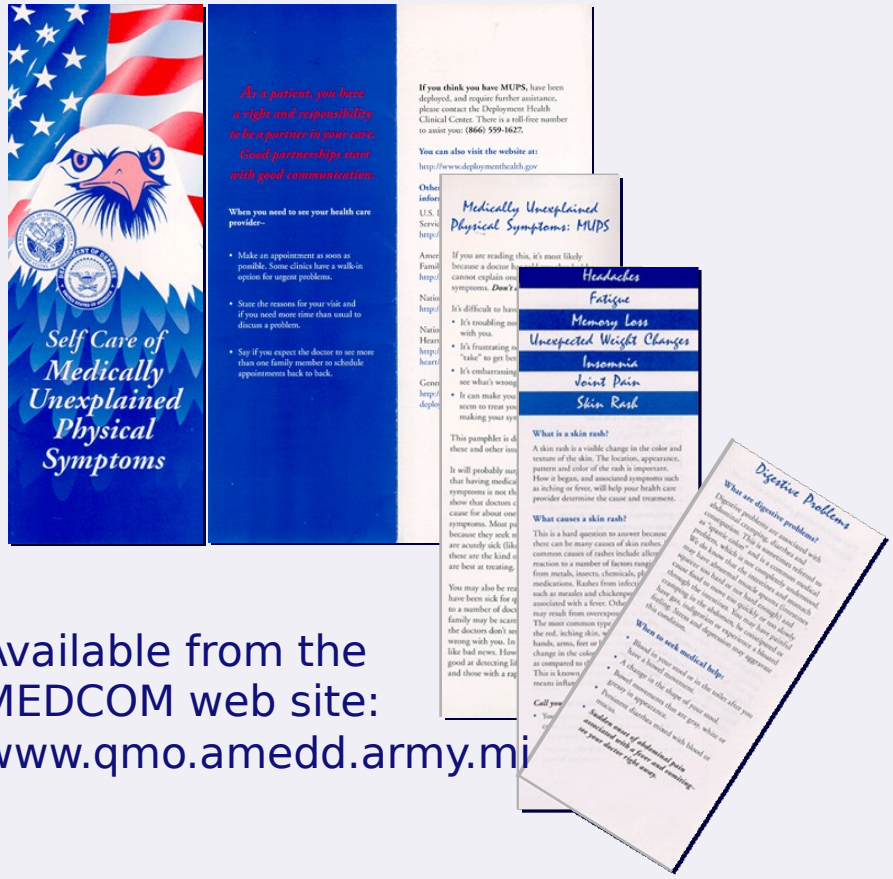
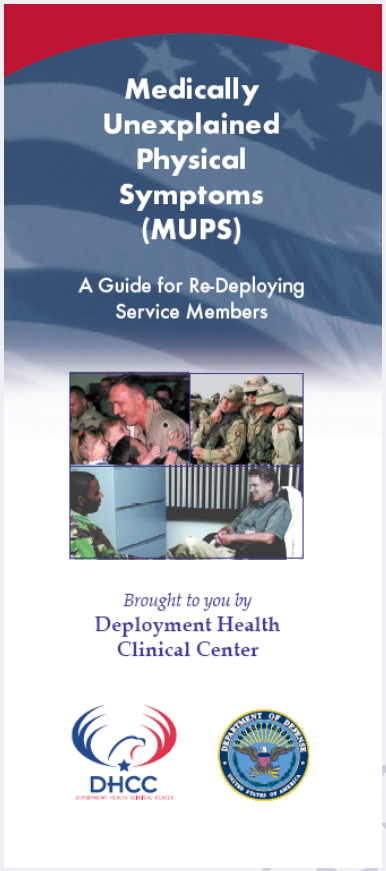


Available from the MEDCOM web site:
www.qmo.amedd.army.mil



Available from the DHCC web site:
www.PDHealth.mil

Overview of PDH-CPG Features

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- Web-based **clinician support**
- Supporting **Center of Excellence**
- Metrics and outcomes **monitoring**

Why is Follow-Up Important?

- Patient follow-up should be
  - Planned
  - Systematic
  - Valued
- Reasons for follow-up
  - Monitor patient progress
  - Demonstrate provider commitment
  - Opportunity to identify previously unidentified problems
  - Track outcomes of care

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Worldwide Web Support for Post-Deployment Health Care

www.PDHealth.mil

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- Information on all deployments and deployment cycle support
- Specific diseases and emerging health concerns
- Web-navigable version of the PDH-CPG
- Online clinical tools
- News and information library
- Provider education and training
- Patient education

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PDH-CPG Web-Based Tools

www.PDHealth.mil

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- PDH Guidelines
  - Overview
  - Guideline
  - Algorithms
  - Implementation
  - Desk Reference Toolbox
  - Tool Kit (Updated by Toolbox
  - CCEP Transition
  - Broadcast, 30 Jan 2002
  - Supporting Guidelines

PDH-CPG Desk Reference Toolbox

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Original 2002 PDH-CPG Tool Kit

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- Large, heavy 23” x 12” x 11” canvas satchel containing:
  - 2.5” Three-ring binder
    - Narrative CPG with questionnaires
    - Sample/description of each tool and support strategy
  - 8.5” x 11” Provider Reference Cards
  - Documentation form (DD 2844)
  - Clinic stamps
  - Reference book(s)
  - List of related web sites
  - Patient informational brochures
  - Patient marketing tools

Redesign of Tool Kit to Toolbox

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- Small portable tools – Toolbox sized to fit on desktop
- Pocket-sized, laminated Reference Cards 5” x 7”
- Ease-of-access
  - Color-coding
  - Index readily available – in Toolbox lid
- Tools not intended as textbooks, but as reminders
  - Concise information
  - Targeted to role of Primary Care Provider
    - Consultation and referral

PDH-CPG Toolbox
Contents

- 24 Toolbox Desk Reference Cards
- 4 Compact Discs (CDs)
  - DHCC CD containing PDH-CPG Interactive Guideline
  - MEDCOM CD containing Clinical Practice and Disease Management Guidelines
  - 2 DHCC CDs containing PDH-CPG multi-media training modules
- Sample copies of PDH-CPG Clinician and Patient Brochures
- Vaccine Healthcare Center's Immunization Tool Kit

Toolbox Table of Contents

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Deployment Health Clinical Center (DHCC) Services

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- Clinical support and consultation
  - Provider Helpline
  - Service Member Helpline
- Direct healthcare services
  - Specialized Care Program (SCP)
  - Specialized Care Program - Operational Stress (SCP-OPS)
  - Post-Deployment Health Assessments (PDHA)
- Proponent for Post-Deployment Health Clinical Practice Guideline (PDH-CPG)

Toolbox Reference Cards
Consult Information

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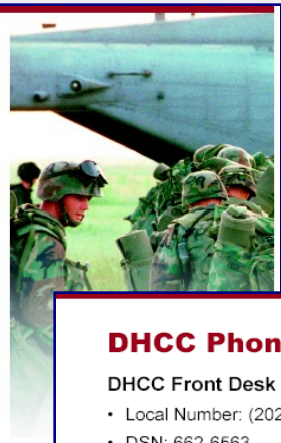
DoD/VA Post-Deployment Health Clinical Practice Guideline (PDH-CPG) Provider Reference Pocket Cards



CONSULT INFORMATION

Clinicians Helpline: 1 (866) 559-1627
DHCC Phone: (202) 782-6563
DSN: 662-6563
Fax: (202) 782-3539
Web Site: www.PDHealth.mil
E-mail: PDHealth@na.amedd.army.mil

DHCC Phone Numbers

DHCC Front Desk

- Local Number: (202) 782-6563
- DSN: 662-6563
- Main Fax Number: (202) 782-3539

DHCC Helpline for Clinicians and Providers

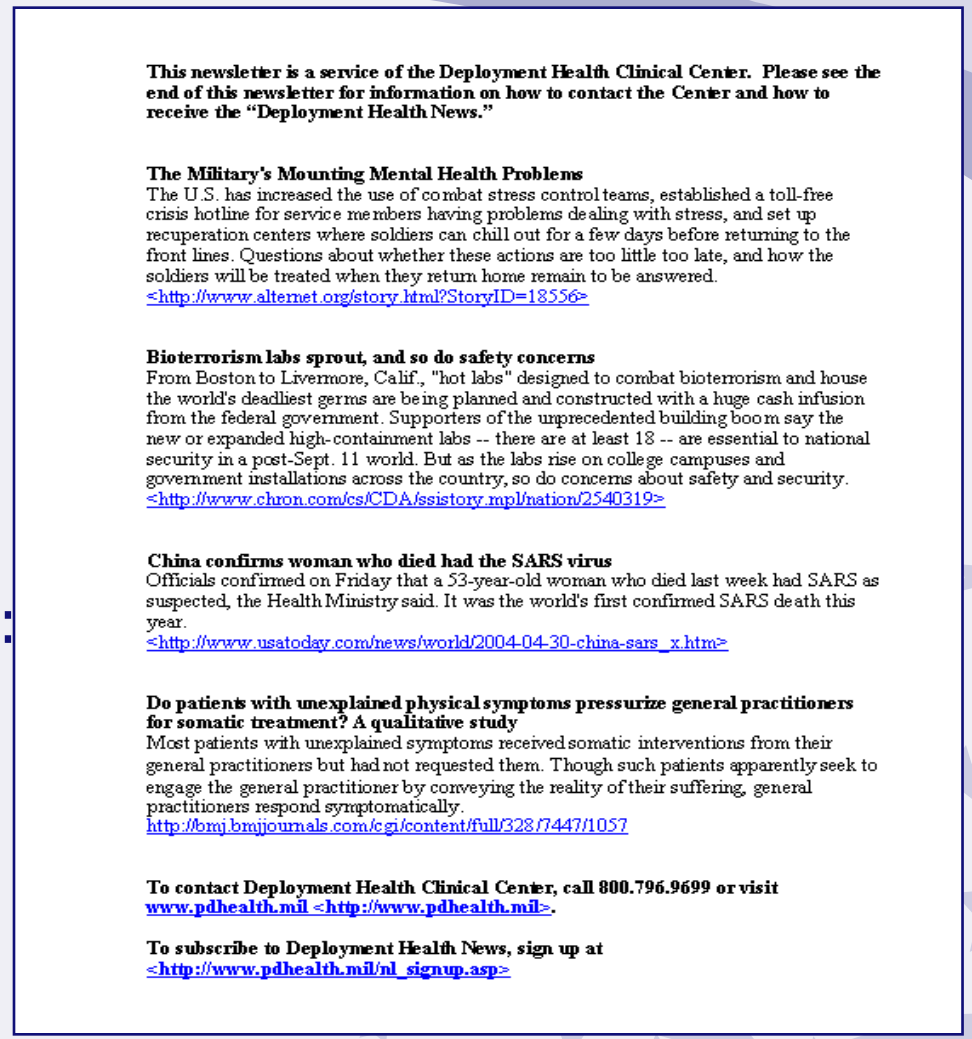
- US Toll Free: 1 (866) 559-1627
- Local Number: (202) 356-0907
- DSN (inside US): 642-0907
- DSN (from Europe): (312) 642-0907

DoD/VA Helpline for Service Members, Veterans, and Families

- Toll Free (inside US): 1 (800) 769-9699
- Toll Free (from Europe): 00800-8666-8666
- Local Number: (202) 782-3577
- DSN (inside US): 662-3577
- DSN (from Europe): (312) 662-3577

Deployment Health News

- Email newsletter each business day
- Deployment-related news articles
- To subscribe, sign up at: *www.pdhealth.mil/nl_signup.asp*



This newsletter is a service of the Deployment Health Clinical Center. Please see the end of this newsletter for information on how to contact the Center and how to receive the "Deployment Health News."

The Military's Mounting Mental Health Problems
The U.S. has increased the use of combat stress control teams, established a toll-free crisis hotline for service members having problems dealing with stress, and set up recuperation centers where soldiers can chill out for a few days before returning to the front lines. Questions about whether these actions are too little too late, and how the soldiers will be treated when they return home remain to be answered.
<http://www.alternet.org/story.html?StoryID=18556>

Bioterrorism labs sprout, and so do safety concerns
From Boston to Livermore, Calif., "hot labs" designed to combat bioterrorism and house the world's deadliest germs are being planned and constructed with a huge cash infusion from the federal government. Supporters of the unprecedented building boom say the new or expanded high-containment labs -- there are at least 18 -- are essential to national security in a post-Sept. 11 world. But as the labs rise on college campuses and government installations across the country, so do concerns about safety and security.
<http://www.chron.com/cs/CDA/ssistory.mpl/nation/2540319>

China confirms woman who died had the SARS virus
Officials confirmed on Friday that a 53-year-old woman who died last week had SARS as suspected, the Health Ministry said. It was the world's first confirmed SARS death this year.
<http://www.usatoday.com/news/world/2004-04-30-china-sars_x.htm>

Do patients with unexplained physical symptoms pressurize general practitioners for somatic treatment? A qualitative study
Most patients with unexplained symptoms received somatic interventions from their general practitioners but had not requested them. Though such patients apparently seek to engage the general practitioner by conveying the reality of their suffering, general practitioners respond symptomatically.
http://bmj.bmjjournals.com/cgi/content/full/328/7447/1057

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To subscribe to Deployment Health News, sign up at <http://www.pdhealth.mil/nl_signup.asp>

DHCC Clinical Care
Specialized Care Programs (SCP and SCP-OPS)

♠ Intensive, 3-week, multidisciplinary, rehabilitative program for
patients with deployment-related chronic illness or Medically
Unexplained Symptoms or post-operational stress symptoms

♠ Available to all military members and family members who
continue to have problems after going through PDH-CPG based
care at local MTF and meet admission criteria (e.g. ambulatory
capable of some exercise) (SCP-OPS for military members only)

- Physical conditioning
- Patient education
- Counseling
- Nutritional
- Occupational therapy
- Relaxation training
- Cognitive-behavioral therapy
- Exposure therapy

Toolbox Table of Contents

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PDH-CPG Algorithms

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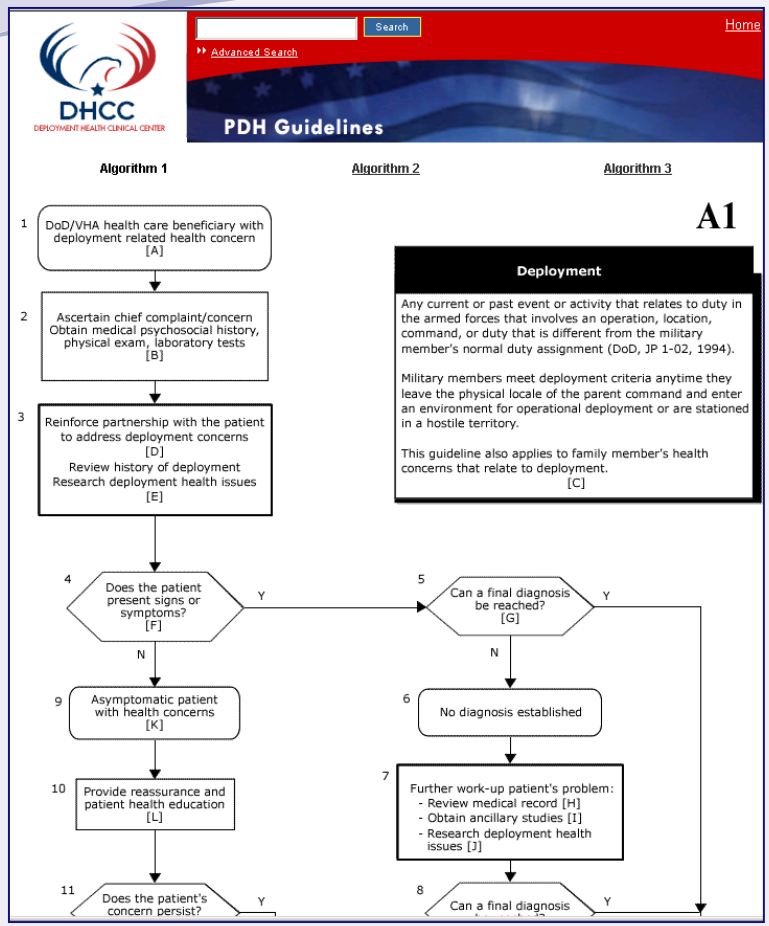
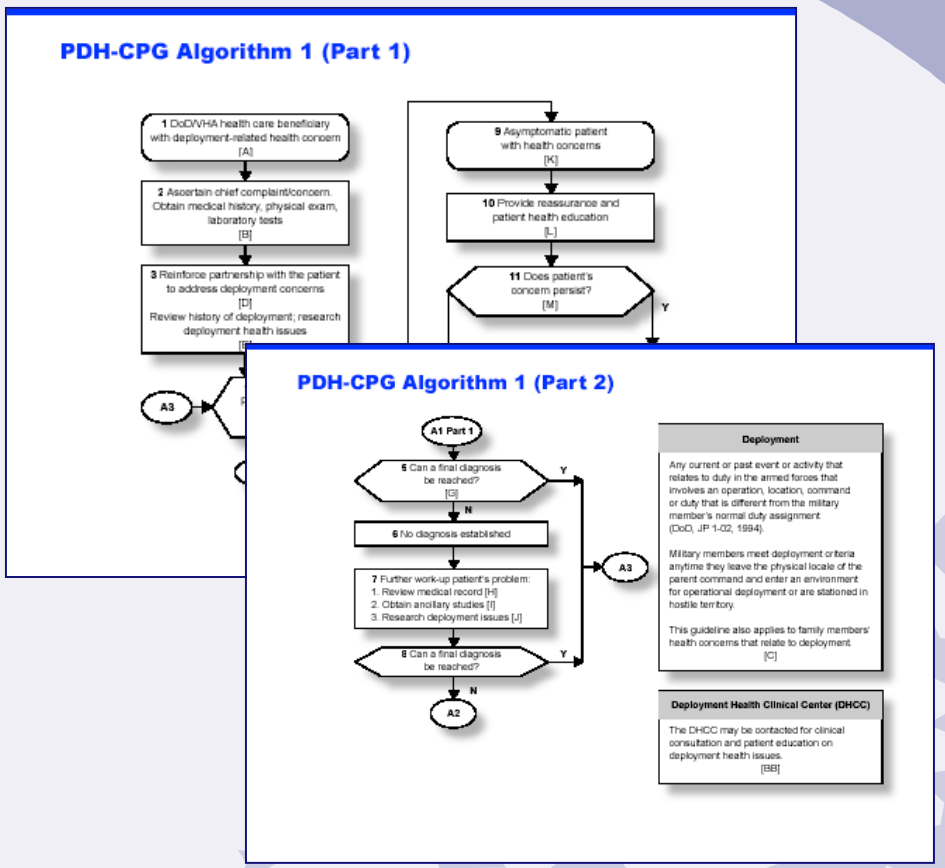


Interactive Guideline on

Toolbox Reference Cards

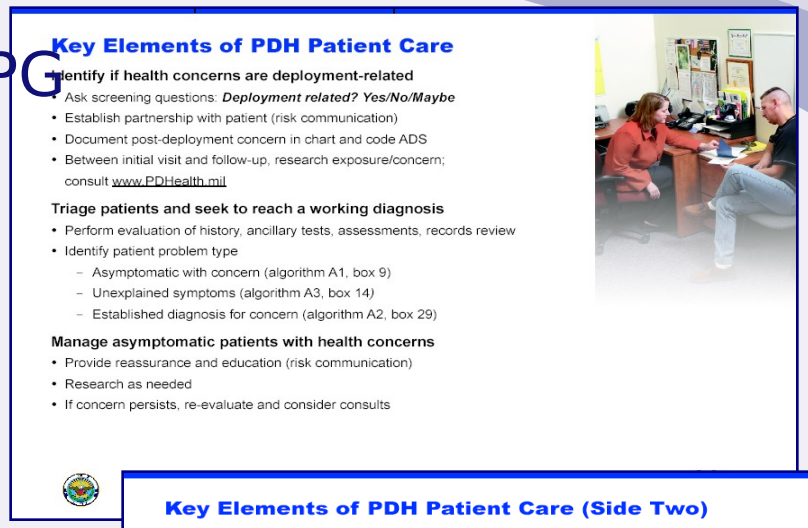


Toolbox Reference Cards

PDH-CPG Provider Reference Card

Key Elements

- Provides synopsis of PDH-CPG Key Elements
  - Identify if health concerns are deployment-related
  - Triage patients and seek to reach a working diagnosis
  - Manage asymptomatic patients with health concerns
  - Manage patients with established diagnosis
  - Manage patients with unexplained

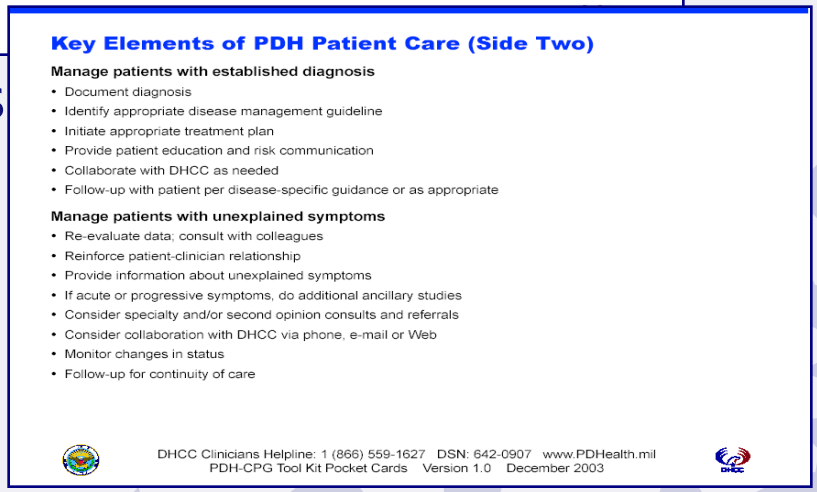


Key Elements of PDH Patient Care

Identify if health concerns are deployment-related
- Ask screening questions: ***Deployment related? Yes/No/Maybe***
- Establish partnership with patient (risk communication)
- Document post-deployment concern in chart and code ADS
- Between initial visit and follow-up, research exposure/concern; consult www.PDHealth.mil

Triage patients and seek to reach a working diagnosis
- Perform evaluation of history, ancillary tests, assessments, records review
- Identify patient problem type
  - Asymptomatic with concern (algorithm A1, box 9)
  - Unexplained symptoms (algorithm A3, box 14)
  - Established diagnosis for concern (algorithm A2, box 29)

Manage asymptomatic patients with health concerns
- Provide reassurance and education (risk communication)
- Research as needed
- If concern persists, re-evaluate and consider consults



Key Elements of PDH Patient Care (Side Two)

Manage patients with established diagnosis
- Document diagnosis
- Identify appropriate disease management guideline
- Initiate appropriate treatment plan
- Provide patient education and risk communication
- Collaborate with DHCC as needed
- Follow-up with patient per disease-specific guidance or as appropriate

Manage patients with unexplained symptoms
- Re-evaluate data; consult with colleagues
- Reinforce patient-clinician relationship
- Provide information about unexplained symptoms
- If acute or progressive symptoms, do additional ancillary studies
- Consider specialty and/or second opinion consults and referrals
- Consider collaboration with DHCC via phone, e-mail or Web
- Monitor changes in status
- Follow-up for continuity of care

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PDH-CPG Tool Kit Pocket Cards Version 1.0 December 2003

Toolbox Reference Cards
PDH Clinic Visit

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♠ Provides guidance for training screeners about the deployment-related question

- How to ask the question
- Emphasizes that deployment is not necessary to have PDH concerns
- How to respond to patients' questions

PDH Concerns Clinic Visit Guidance

How to ask the question: "Is your health concern today related to a deployment?"
Focus on chief complaint rather than if patient has **any** PDH complaints

Deployment is not necessary for patient to have PDH concerns
- Spouse or child may have concern related to sponsor's recent deployment
- Patient may have questions about future or past deployments
- Ask this question whether patient is active duty, retired, family member, veteran, deployed or non-deployed

How to respond to patients questions
1) "What do you mean?" or "What do you mean, deployment-related?"
Goal is to record patient's perception of deployment-relatedness not your own
- To help patient answer, ask if patient or a loved one has been deployed.
  If so, is today's visit related to that deployment
- Review examples of deployment concern or condition (see reverse)

2) "What is deployment?" Avoid narrow definitions of deployment. Offer a few examples (see reverse),
and return to the question: "Do you feel your health concern today is related to deployment?"

3) "I don't know if it
- When in doubt, alw

DHC

PDH Concerns Clinic Visit Guidance (Side Two)

Deployment Examples

Overseas Deployment
- Military liaison and training support
- Humanitarian assistance
- Low-intensity conflict
- Peacekeeping
- Joint or coalition force exercises
- Combat/War

Within the US
- Fighting forest fires
- Maintaining civil order
- Construction projects
- Providing disaster relief
- Responding to terrorist attack
- Drug interdiction
- Airport security

Deployment-Related Concern or Condition Examples
- Deployed man twists his ankle; injury persists after returning home
- Post-deployed woman blood-donor expresses concern about donating
- Although not deployed, man is concerned about effects of vaccine
- Spouse complains of rash after washing clothes worn by member while deployed
- While deployed, woman suffers a toxic exposure and later gets sick from it
- Spouse complains that her child is having nightmares since member returned from combat

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Toolbox Reference Cards

PDH ICD-9-CM Coding

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PDH ICD-9-CM Coding

At each Post-Deployment Visit (Primary or Specialty Care) at least *two* ICD-9-CM codes must be assigned and documented by the provider.

ALL Deployment-Related Visits must have the code:

V70.5_ _6, Deployment-Related Visit

and

Deployment-Related Presenting Problem ICD-9-CM Code(s):

- **Asymptomatic Concern — V65.5**
- **Specific Diagnosis or Symptom(s) —** that patient believes is deployment-related, use the **diagnosis or symptom code**
- **Medically Unexplained Physical Symptoms — 799.8** (use only after several visits and appropriate diagnostic evaluation reveals no specific diagnosis for a chronic condition)

PDH ICD-9-CM Coding Example

Type of Patient	Example	Deployment-Related Code	Health Concern Code
Asymptomatic Concerned, Deployment-Related	Pregnant wife of active duty soldier with concerns about depleted uranium. This is a follow-up visit after PCM has researched the issue.	V70.5_ _6	V65.5
Symptoms, Deployment-Related	13 y/o girl with significant weight loss. Girl's mother suspects concern is related to father's deployment to Iraq.	V70.5_ _6	783.21 (abnormal weight loss)
Symptoms, Deployment-Related	23 y/o Marine developed poison ivy rash after FTX to field a few days ago.	V70.5_ _6	692.6 (contact dermatitis due to plants)
Medically Unexplained Physical Symptoms, Deployment-Related	49 y/o retired E-8 has been evaluated over 3 months (5 visits) for intermittent joint pain, intermittent vertigo and severe fatigue. Patient states he believes he was exposed to something in Kuwait on mission two years ago. Work-up to date is complete, but negative.	V70.5_ _6	799.8 (other ill-defined conditions and unknown causes of morbidity)

Toolbox Table of Contents

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Emerging Health Concerns (EHC) Resources on *www.PDHealth.mil*

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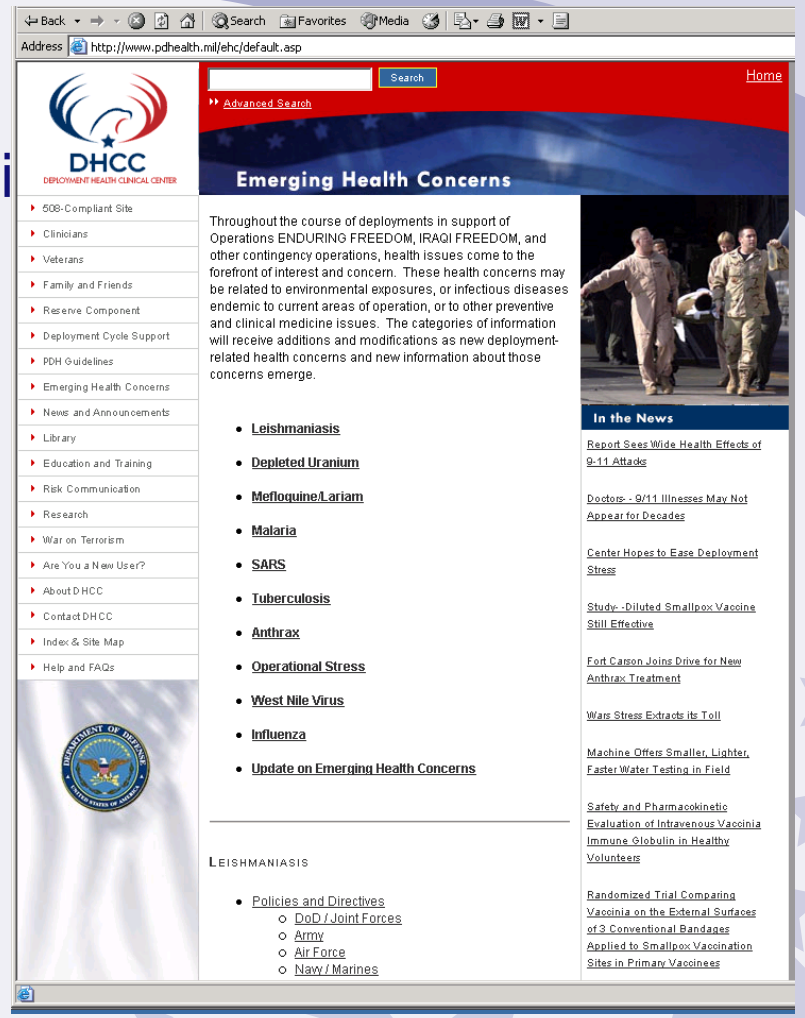
DEPLOYMENT HEALTH CLINICAL CENTER

- Reference sources
  - Tri-Service policies and directi
  - Related internet links
- Provider information
  - Clinical guidance
  - Fact sheets
  - Forms and measures
  - Educational material
  - Research information
- Patient information
  - Fact sheets
  - Educational material



Emerging Health Concerns (EHC) Topics on *www.PDHealth.mil*

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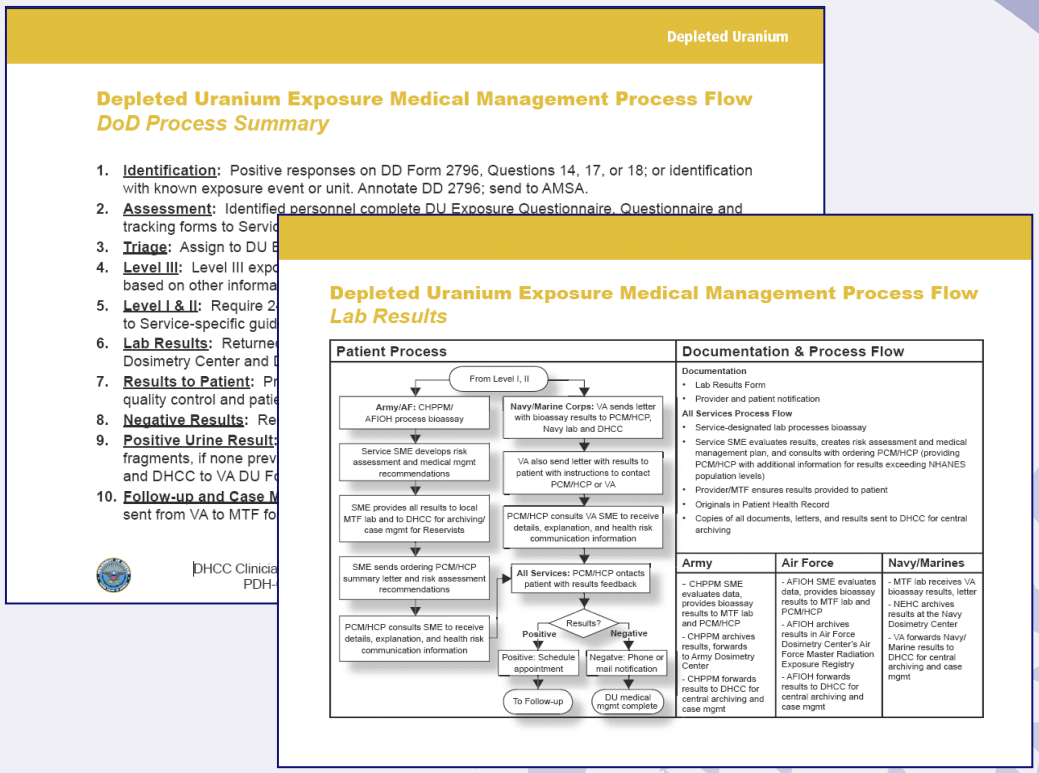
- Leishmaniasis
- Depleted Uranium – also has a Toolbox Reference Card
- Mefloquine/Lariam®
- Malaria
- SARS
- Tuberculosis
- Anthrax
- Operational Stress
- West Nile Virus
- Influenza
- Update on EHC



Depleted Uranium

Depleted Uranium Exposure Medical Management Process Flow
DoD Process Summary

1. **Identification:** Positive responses on DD Form 2796, Questions 14, 17, or 18; or identification with known exposure event or unit. Annotate DD 2796; send to AMSA.
2. **Assessment:** Identified personnel complete DU Exposure Questionnaire. Questionnaire and tracking forms to Servic
3. **Triage:** Assign to DU E
4. **Level III:** Level III expo based on other informa
5. **Level I & II:** Require 2 to Service-specific guid
6. **Lab Results:** Returne Dosimetry Center and D
7. **Results to Patient:** Pr quality control and patie
8. **Negative Results:** Re
9. **Positive Urine Result:** fragments, if none prev and DHCC to VA DU Fo
10. **Follow-up and Case M** sent from VA to MTF fo

DHCC Clinica
PDH-

Depleted Uranium Exposure Medical Management Process Flow
Lab Results

Patient Process

Documentation & Process Flow

Documentation
- Lab Results Form
- Provider and patient notification

All Services Process Flow
- Service-designated lab processes bioassay
- Service SME evaluates results, creates risk assessment and medical management plan, and consults with ordering PCM/HCP (providing PCM/HCP with additional information for results exceeding NHANES population levels)
- Provider/MTF ensures results provided to patient
- Originals in Patient Health Record
- Copies of all documents, letters, and results sent to DHCC for central archiving

Army	Air Force	Navy/Marines
- CHPPM SME evaluates data, provides bioassay results to MTF lab and PCM/HCP - CHPPM archives results, forwards to Army Dosimetry Center - CHPPM forwards results to DHCC for central archiving and case mgmt	- AFIOH SME evaluates data, provides bioassay results to MTF lab and PCM/HCP - AFIOH archives results in Air Force Dosimetry Center's Air Force Master Radiation Exposure Registry - AFIOH forwards results to DHCC for central archiving and case mgmt	- MTF lab receives VA bioassay results, letter - NEHC archives results at the Navy Dosimetry Center - VA forwards Navy/ Marine results to DHCC for central archiving and case mgmt

Associated Guidelines on *www.PDHealth.mil*

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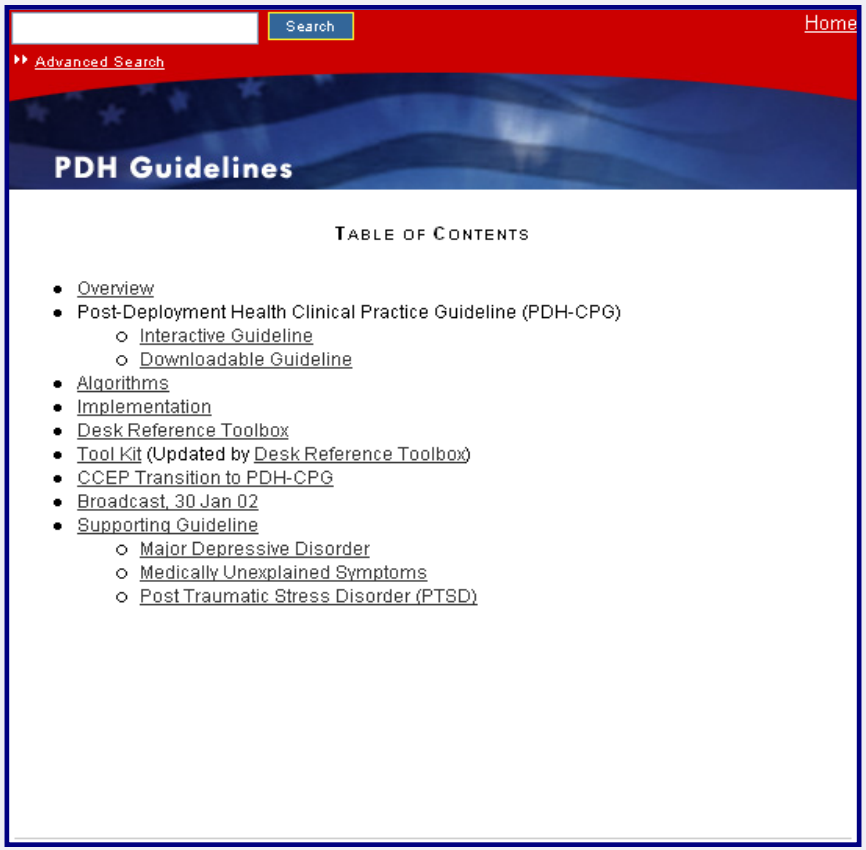

- Major Depressive Disorder (MDD)
- Medically Unexplained Symptoms (MUS)
- Post Traumatic Stress Disorder (PTSD)

Toolbox Reference Cards
Associated Guidelines

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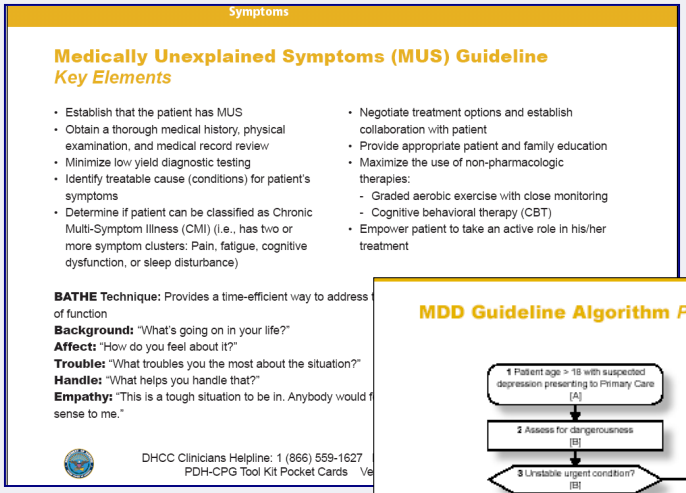

Symptoms

Medically Unexplained Symptoms (MUS) Guideline
Key Elements

- Establish that the patient has MUS
- Obtain a thorough medical history, physical examination, and medical record review
- Minimize low yield diagnostic testing
- Identify treatable cause (conditions) for patient's symptoms
- Determine if patient can be classified as Chronic Multi-Symptom Illness (CMI) (i.e., has two or more symptom clusters: Pain, fatigue, cognitive dysfunction, or sleep disturbance)
- Negotiate treatment options and establish collaboration with patient
- Provide appropriate patient and family education
- Maximize the use of non-pharmacologic therapies:
  - Graded aerobic exercise with close monitoring
  - Cognitive behavioral therapy (CBT)
- Empower patient to take an active role in his/her treatment

BATHE Technique: Provides a time-efficient way to address
of function
Background: "What's going on in your life?"
Affect: "How do you feel about it?"
Trouble: "What troubles you the most about the situation?"
Handle: "What helps you handle that?"
Empathy: "This is a tough situation to be in. Anybody would
sense to me."

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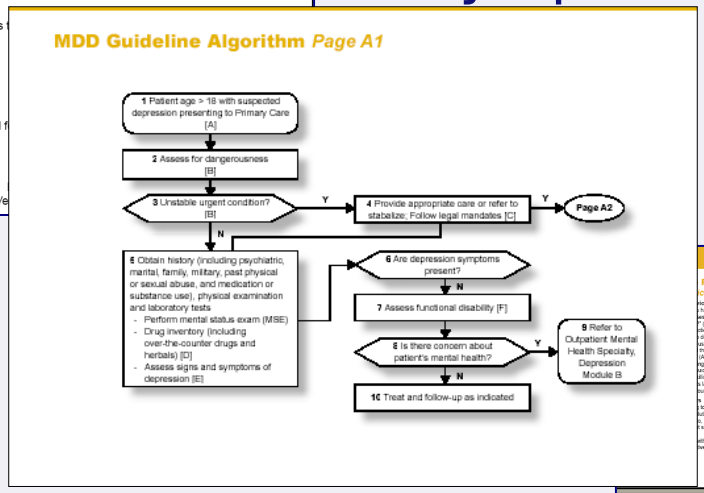
PDH-CPG Tool Kit Pocket Cards Ve

♠ Medically Unexplained Symptoms



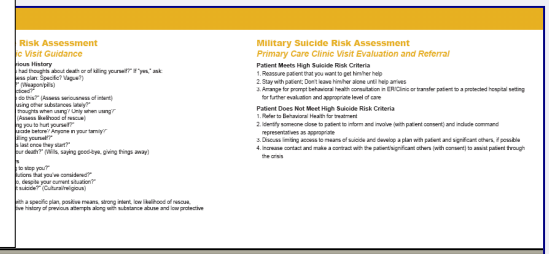
MDD Guideline Algorithm *Page A1*

1 Patient age > 18 with suspected depression presenting to Primary Care [A]
2 Assess for dangerousness [B]
3 Unstable urgent condition? [B]
4 Provide appropriate care or refer to stabilize. Follow legal mandates [C]
Page A2
5 Obtain history (including psychiatric, marital, family, military, past physical or sexual abuse, and medication or substance use), physical examination and laboratory tests
- Perform mental status exam (MSE)
- Drug inventory (including over-the-counter drugs and herbals) [D]
- Assess signs and symptoms of depression [E]

6 Are depression symptoms present?
7 Assess functional disability [F]
8 Is there concern about patient's mental health?
9 Refer to Outpatient Mental Health Specialty, Depression Module B
10 Treat and follow-up as indicated

Y
N

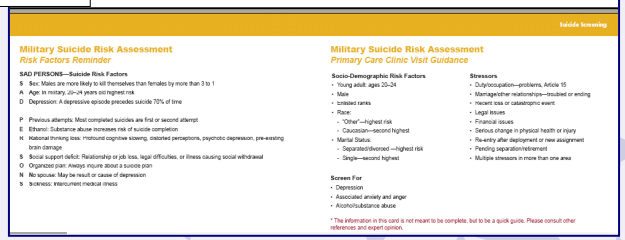
♠ Major Depressive Disorder



Military Suicide Risk Assessment
Primary Care Clinic Visit Evaluation and Referral

Patient Meets High Suicide Risk Criteria
1. Reassure patient that you want to get him/her help
2. Stay with patient. Don't leave him/her alone until help arrives
3. Arrange for prompt behavioral health consultation in ER/Clinic or transfer patient to a protected hospital setting for further evaluation and appropriate level of care

Patient Does Not Meet High Suicide Risk Criteria
1. Refer to Behavioral Health for treatment
2. Identify someone close to patient to inform and involve (with patient consent) and include command representatives as appropriate
3. Discuss limiting access to means of suicide and develop a plan with patient and significant others, if possible
4. Increase contact and make a contract with the patient/significant others (with consent) to assist patient through the crisis



Suicide Screening

Military Suicide Risk Assessment
Risk Factors Reminder

SAD PERSONS—Suicide Risk Factors
S Sex: Males are more likely to kill themselves than females by more than 3 to 1
A Age: In military, 20–24 years old highest risk
D Depression: A depressive episode precedes suicide 70% of time
P Previous attempts: Most completed suicides are first or second attempt
E Ethanol: Substance abuse increases risk of suicide completion
H Hational thinking loss: Profound cognitive slowing, distorted perceptions, psychotic depression, pre-existing brain damage
S Social support deficit: Relationship or job loss, legal difficulties, or illness causing social withdrawal
O Organized plan: Always inquire about a suicide plan
N No spouse: May be result or cause of depression
S Sickness: Intercurrent medical illness

Military Suicide Risk Assessment
Primary Care Clinic Visit Guidance

Socio-Demographic Risk Factors
- Young adult: ages 20–24
- Male
- Enlisted ranks
- Race:
  - "Other"—highest risk
  - Caucasian—second highest
- Marital Status:
  - Separated/divorced —highest risk
  - Single—second highest

Stressors
- Duty/occupation—problems, Article 15
- Marriage/other relationships—troubled or ending
- Recent loss or catastrophic event
- Legal issues
- Financial issues
- Serious change in physical health or injury
- Re-entry after deployment or new assignment
- Pending separation/retirement
- Multiple stressors in more than one area

Screen For
- Depression
- Associated anxiety and anger
- Alcohol/substance abuse

* The information in this card is not meant to be complete, but to be a quick guide. Please consult other references and expert opinion.

♠ Suicide

Toolbox Table of Contents

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Toolbox Reference Cards
Risk Communication

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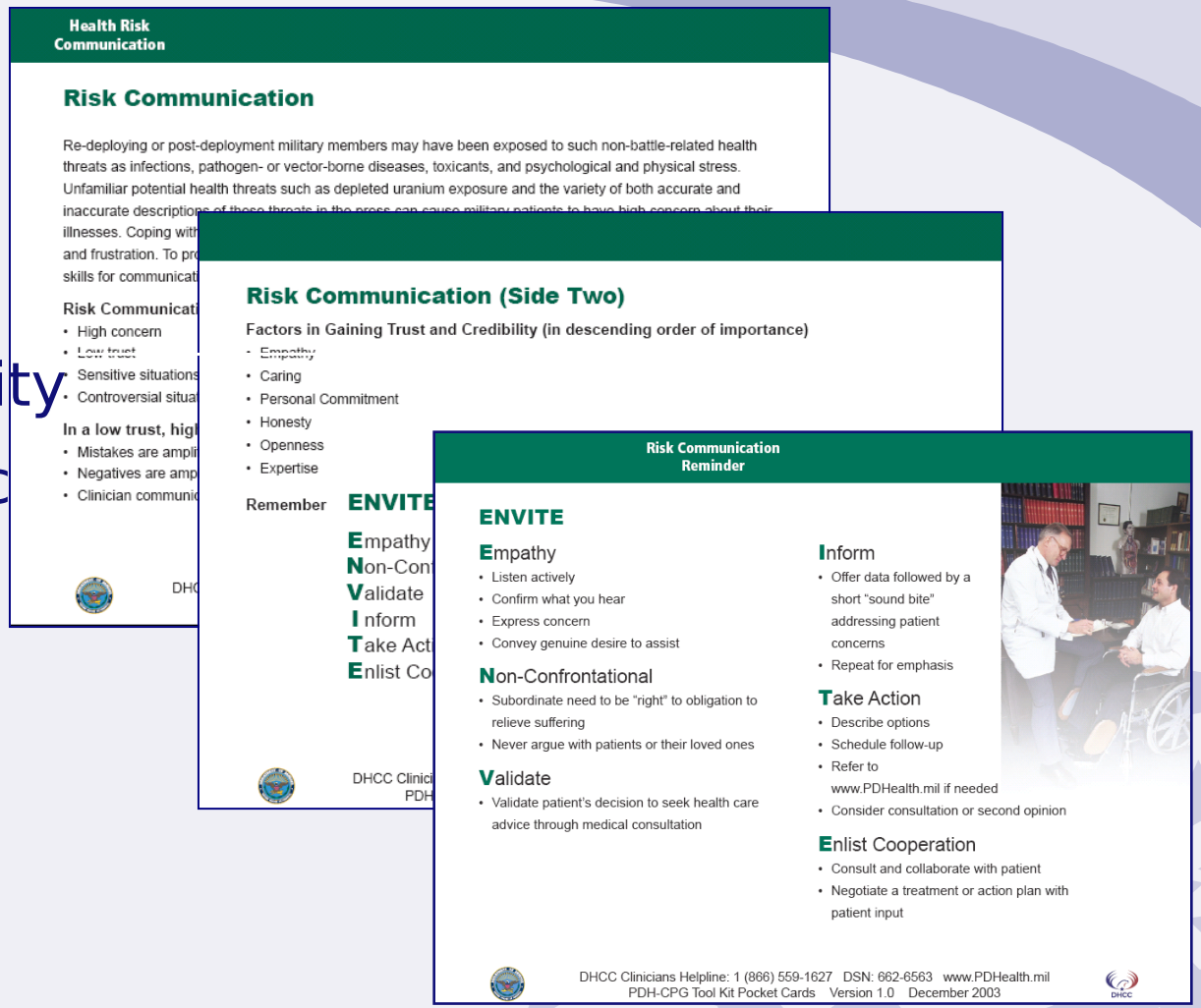
- Definition
- Factors in gaining trust and credibility
- *ENVITE* mnemonic



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Deployment Health Assessment Forms and Primers

DHCC
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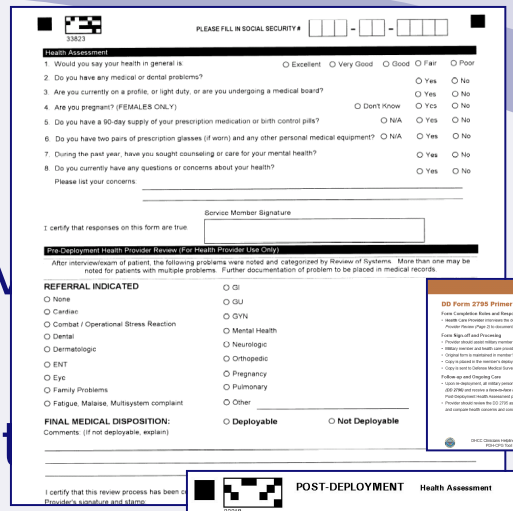
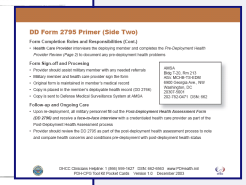
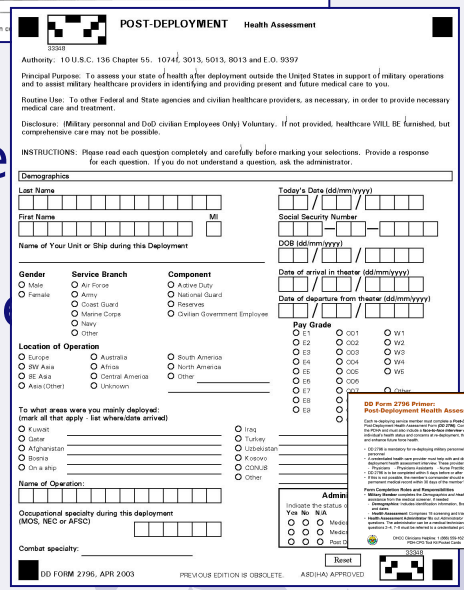
- DD Form 2795, Pre-Deployment Health Assessment
  - Reviewed by a credentialed prov for positive responses
- DD Form 2796, Post-Deployment Health Assessment
  - Face to face assessment by trained he care provider (physician, physician assistant, nurse practitioner, independe duty corpsman/medical technician)
- Available on *www.PDHealth.mil*







Post-Deployment Health Assessment (PDHA)
Background and Purpose

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- Enhanced PDHA process
  - Developed in response to Operation Iraqi Freedom
  - Purpose – Enhanced post-deployment health screening for all returning service members
- Part of Redeployment Process, elements include
  - DD Form 2796 and follow-up referral
  - HIV screening and blood repository
  - Tuberculin skin testing at redeployment and at 3-6 months based on risk assessment
  - Medical threat and benefits briefings with handouts
  - Malaria post-exposure chemoprophylaxis as appropriate

DD Form 2844 - Post Deployment Medical Assessment Form and Primer

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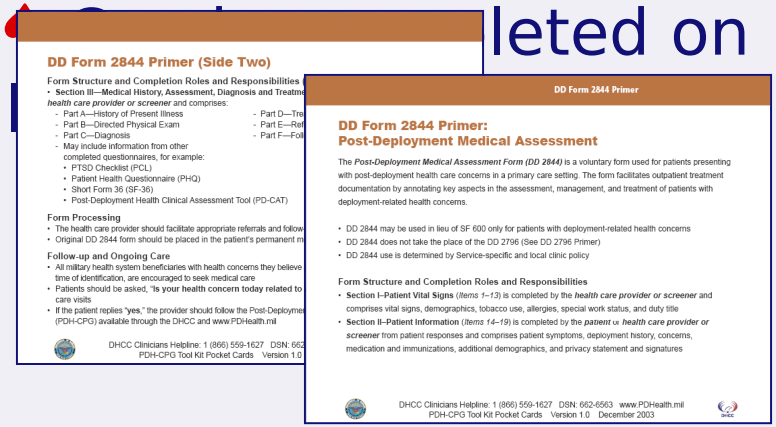
- Optional form
- Used in place of SF 600
  for documenting post-deployment evaluation
- [illegible]leted on



DD Form 2844 Primer (Side Two)

Form Structure and Completion Roles and Responsibilities

- Section III—Medical History, Assessment, Diagnosis and Treatme

health care provider or screener and comprises:

- Part A—History of Present Illness
- Part B—Directed Physical Exam
- Part C—Diagnosis
- May include information from other completed questionnaires, for example:
  - PTSD Checklist (PCL)
  - Patient Health Questionnaire (PHQ)
  - Short Form 36 (SF-36)
  - Post-Deployment Health Clinical Assessment Tool (PD-CAT)

Form Processing

- The health care provider should facilitate appropriate referrals and follow
- Original DD 2844 form should be placed in the patient's permanent m

Follow-up and Ongoing Care

- All military health system beneficiaries with health concerns they believe time of identification, are encouraged to seek medical care
- Patients should be asked, "**Is your health concern today related to** care visits
- If the patient replies "yes," the provider should follow the Post-Deployme (PDH-CPG) available through the DHCC and www.PDHealth.mil

DHCC Clinicians Helpline: 1 (866) 559-1627 DSN: 662
PDH-CPG Tool Kit Pocket Cards Version 1.0

DD Form 2844 Primer

DD Form 2844 Primer:
Post-Deployment Medical Assessment

The ***Post-Deployment Medical Assessment Form (DD 2844)*** is a voluntary form used for patients presenting with post-deployment health care concerns in a primary care setting. The form facilitates outpatient treatment documentation by annotating key aspects in the assessment, management, and treatment of patients with deployment-related health concerns.

- DD 2844 may be used in lieu of SF 600 only for patients with deployment-related health concerns
- DD 2844 does not take the place of the DD 2796 (See DD 2796 Primer)
- DD 2844 use is determined by Service-specific and local clinic policy

Form Structure and Completion Roles and Responsibilities

- **Section I–Patient Vital Signs** (*Items 1–13*) is completed by the ***health care provider or screener*** and comprises vital signs, demographics, tobacco use, allergies, special work status, and duty title
- **Section II–Patient Information** (*Items 14–19*) is completed by the ***patient*** or ***health care provider or screener*** from patient responses and comprises patient symptoms, deployment history, concerns, medication and immunizations, additional demographics, and privacy statement and signatures

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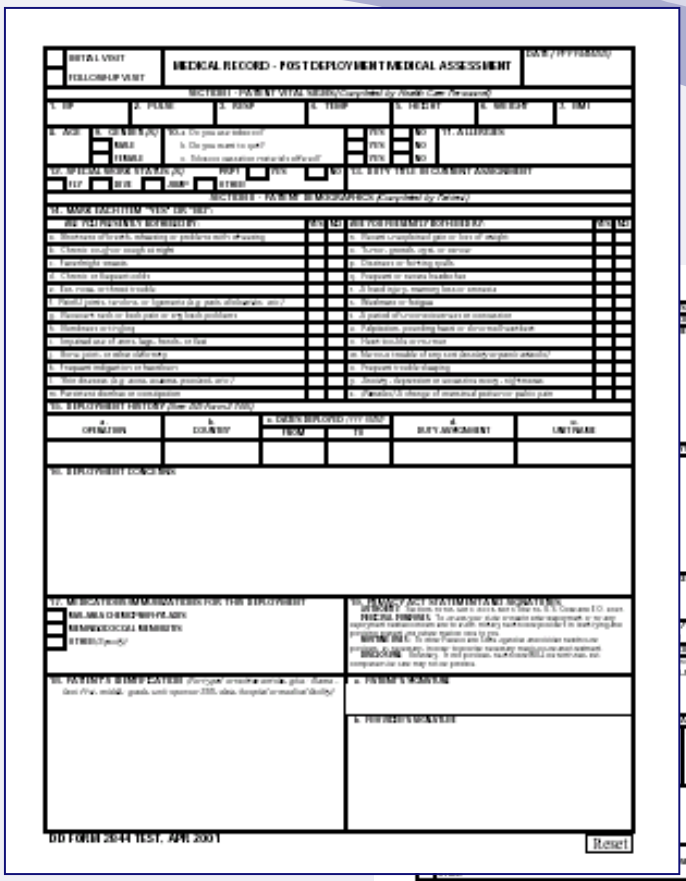
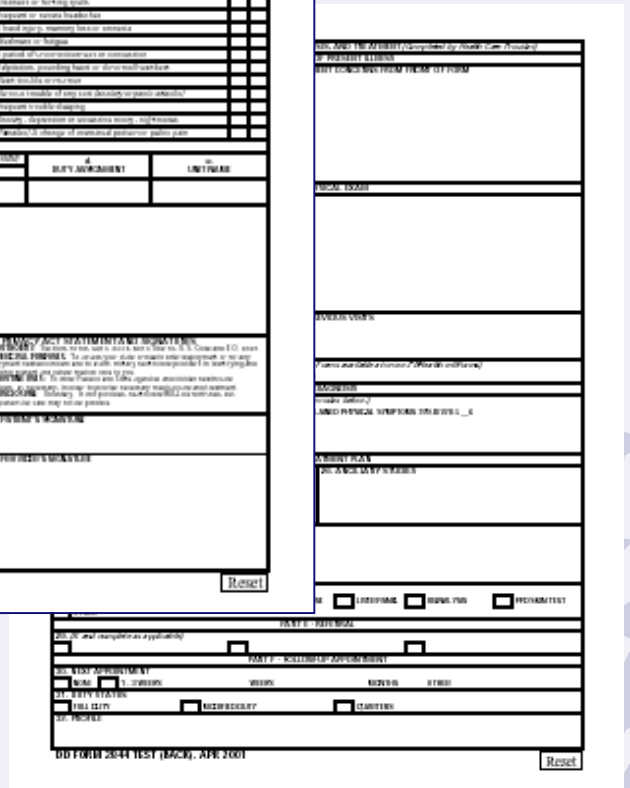


INITIAL VISIT
FOLLOW-UP VISIT

MEDICAL RECORD - POST DEPLOYMENT MEDICAL ASSESSMENT

DD FORM 2844 TEST, APR 2001

Reset



DD FORM 2844 TEST (BACK), APR 2001

Reset

SF-36v2 - Health Survey Form and Primer

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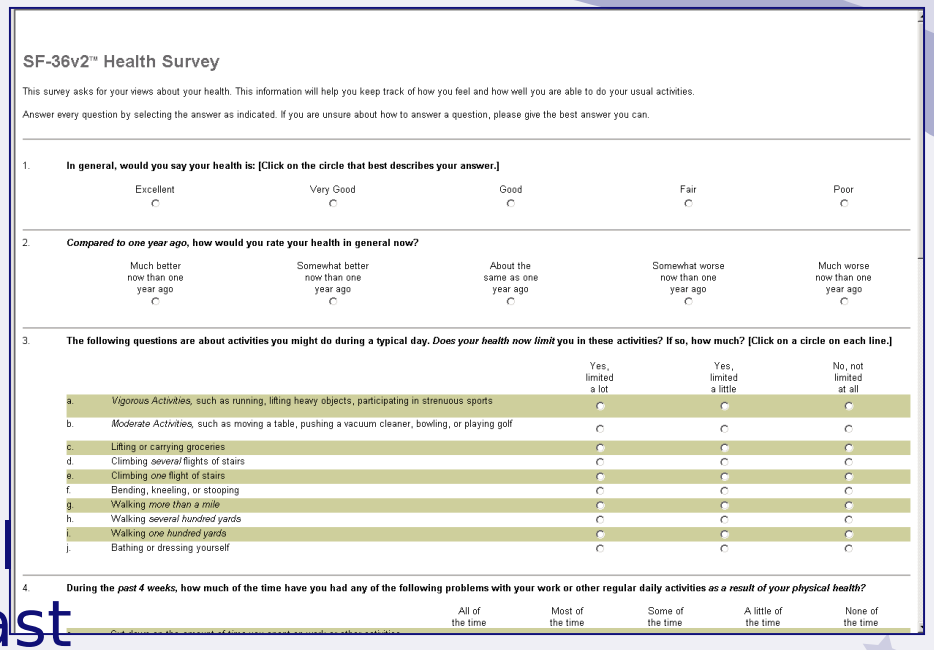
- Short, generic measure of health-related functioning
- Comprised of 36 questions asking the patient to describe physical or emotional problems over the past four weeks
- Can be completed and scored on line at *www.PDHealth.mil*



SF-36v2™ Health Survey

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. **In general, would you say your health is: [Click on the circle that best describes your answer.]**

Excellent	Very Good	Good	Fair	Poor
○	○	○	○	○

2. ***Compared to one year ago*, how would you rate your health in general now?**

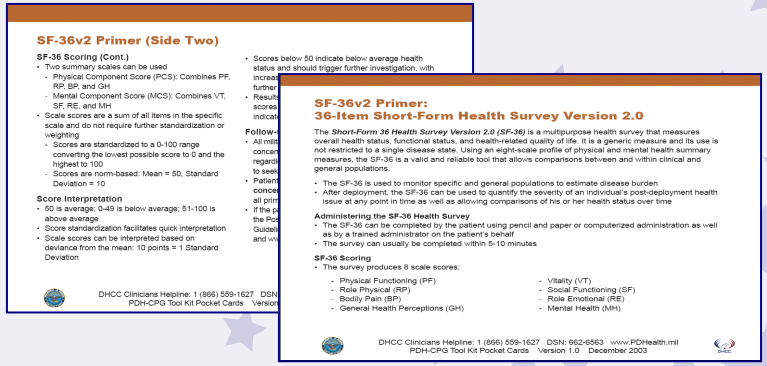
Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
○	○	○	○	○

3. **The following questions are about activities you might do during a typical day. *Does your health now limit* you in these activities? If so, how much? [Click on a circle on each line.]**

		Yes, limited a lot	Yes, limited a little	No, not limited at all
a.	*Vigorous Activities*, such as running, lifting heavy objects, participating in strenuous sports	○	○	○
b.	*Moderate Activities*, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
c.	Lifting or carrying groceries	○	○	○
d.	Climbing *several* flights of stairs	○	○	○
e.	Climbing *one* flight of stairs	○	○	○
f.	Bending, kneeling, or stooping	○	○	○
g.	Walking *more than a mile*	○	○	○
h.	Walking *several hundred yards*	○	○	○
i.	Walking *one hundred yards*	○	○	○
j.	Bathing or dressing yourself	○	○	○

4. **During the *past 4 weeks*, how much of the time have you had any of the following problems with your work or other regular daily activities *as a result of your physical health?***

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Cut down on the amount of time you spent on work or other activities					



SF-36v2 Primer (Side Two)

SF-36 Scoring (Cont.)

- Two summary scales can be used
  - Physical Component Score (PCS): Combines PF, RP, BP, and GH
  - Mental Component Score (MCS): Combines VT, SF, RE, and MH
- Scale scores are a sum of all items in the specific scale and do not require further standardization or weighting
  - Scores are standardized to a 0-100 range converting the lowest possible score to 0 and the highest to 100
  - Scores are norm-based: Mean = 50, Standard Deviation = 10

Score Interpretation

- 50 is average; 0-49 is below average; 51-100 is above average
- Score standardization facilitates quick interpretation
- Scale scores can be interpreted based on deviance from the mean: 10 points = 1 Standard Deviation
- Scores below 50 indicate below average health status and should trigger further investigation, with increas
- Result
  scores
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Follow-

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SF-36v2 Primer:
36-Item Short-Form Health Survey Version 2.0

The ***Short-Form 36 Health Survey Version 2.0 (SF-36)*** is a multipurpose health survey that measures overall health status, functional status, and health-related quality of life. It is a generic measure and its use is not restricted to a single disease state. Using an eight-scale profile of physical and mental health summary measures, the SF-36 is a valid and reliable tool that allows comparisons between and within clinical and general populations.

- The SF-36 is used to monitor specific and general populations to estimate disease burden
- After deployment, the SF-36 can be used to quantify the severity of an individual's post-deployment health issue at any point in time as well as allowing comparisons of his or her health status over time

Administering the SF-36 Health Survey

- The SF-36 can be completed by the patient using pencil and paper or computerized administration as well as by a trained administrator on the patient's behalf
- The survey can usually be completed within 5-10 minutes

SF-36 Scoring

- The survey produces 8 scale scores:
  - Physical Functioning (PF)
  - Role Physical (RP)
  - Bodily Pain (BP)
  - General Health Perceptions (GH)
  - Vitality (VT)
  - Social Functioning (SF)
  - Role Emotional (RE)
  - Mental Health (MH)

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Post Traumatic Stress Disorder Checklists, Primer and CPG

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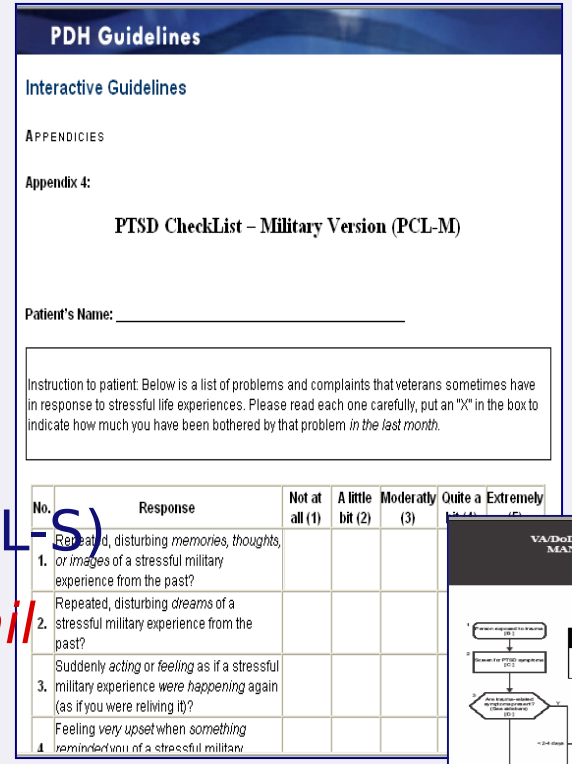
- Assesses trauma-related distress
- Self-administered
- 3 Versions
  - Civilian Version (PCL-C)
  - Military Version (PCL-M)
  - Stress Specific Version (PCL-S)
- A[illegible]ww.PDHealth.mil



PDH Guidelines

Interactive Guidelines

APPENDICIES

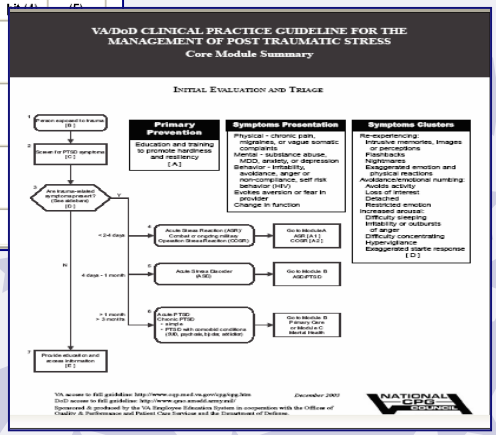
Appendix 4:

PTSD CheckList – Military Version (PCL-M)

Patient's Name: _____

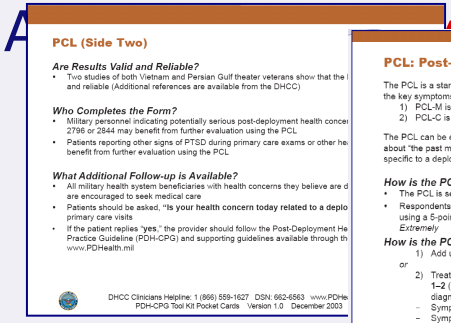
Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month.*

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a [illegible]	Extremely
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful military experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful military experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening* again (as if you were reliving it)?					
4	Feeling *very upset* when *something reminded* you of a stressful military					



VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POST TRAUMATIC STRESS
Core Module Summary

INITIAL EVALUATION AND TRIAGE



PCL (Side Two)

Are Results Valid and Reliable?
- Two studies of both Vietnam and Persian Gulf theater veterans show that the I and reliable (Additional references are available from the DHCC)

Who Completes the Form?
- Military personnel indicating potentially serious post-deployment health concer 2796 or 2844 may benefit from further evaluation using the PCL
- Patients reporting other signs of PTSD during primary care exams or other he benefit from further evaluation using the PCL

What Additional Follow-up is Available?
- All military health system beneficiaries with health concerns they believe are d are encouraged to seek medical care
- Patients should be asked, "**Is your health concern today related to a deplo** primary care visits
- If the patient replies "yes," the provider should follow the Post-Deployment He Practice Guideline (PDH-CPG) and supporting guidelines available through th www.PDHealth.mil

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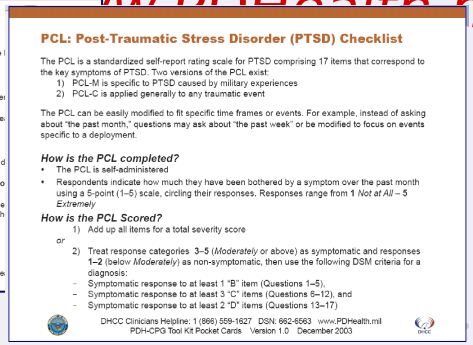

PCL: Post-Traumatic Stress Disorder (PTSD) Checklist

The PCL is a standardized self-report rating scale for PTSD comprising 17 items that correspond to the key symptoms of PTSD. Two versions of the PCL exist:
1) PCL-M is specific to PTSD caused by military experiences
2) PCL-C is applied generally to any traumatic event

The PCL can be easily modified to fit specific time frames or events. For example, instead of asking about "the past month," questions may ask about "the past week" or be modified to focus on events specific to a deployment.

How is the PCL completed?
- The PCL is self-administered
- Respondents indicate how much they have been bothered by a symptom over the past month using a 5-point (1–5) scale, circling their responses. Responses range from 1 *Not at All* – 5 *Extremely*

How is the PCL Scored?
1) Add up all items for a total severity score

or

2) Treat response categories 3–5 (*Moderately* or above) as symptomatic and responses 1–2 (below *Moderately*) as non-symptomatic, then use the following DSM criteria for a diagnosis:
- Symptomatic response to at least 1 "B" item (Questions 1–5),
- Symptomatic response to at least 3 "C" items (Questions 6–12), and
- Symptomatic response to at least 2 "D" items (Questions 13–17)

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Toolbox Table of Contents

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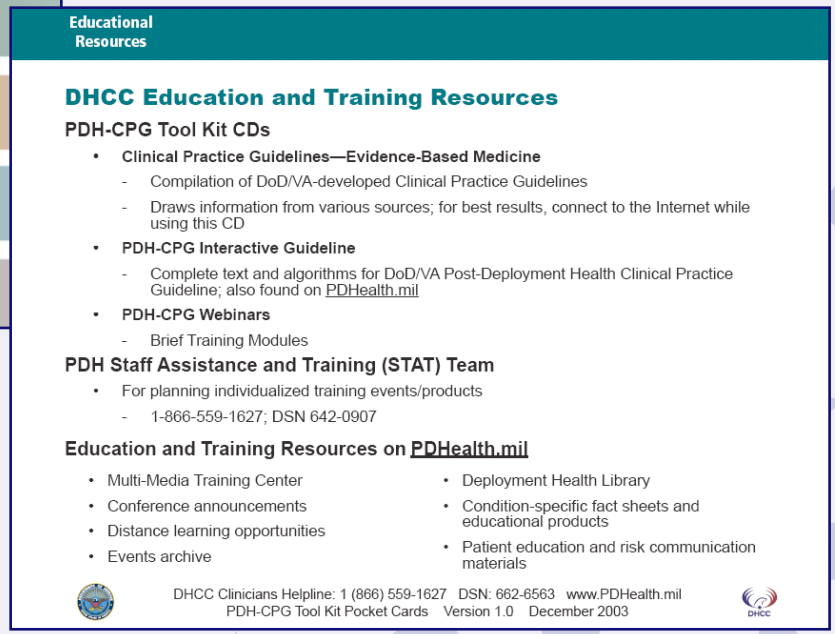
- Contact Information and Resources
- PDH-CPG Guideline Elements
- Specific Medical Conditions and Concerns
- Risk Communication
- Screening and Outcome Measures
- Training
- Process Improvement and Metrics



Educational Resources

DHCC Education and Training Resources

PDH-CPG Tool Kit CDs

- **Clinical Practice Guidelines—Evidence-Based Medicine**
  - Compilation of DoD/VA-developed Clinical Practice Guidelines
  - Draws information from various sources; for best results, connect to the Internet while using this CD
- **PDH-CPG Interactive Guideline**
  - Complete text and algorithms for DoD/VA Post-Deployment Health Clinical Practice Guideline; also found on PDHealth.mil
- **PDH-CPG Webinars**
  - Brief Training Modules

PDH Staff Assistance and Training (STAT) Team

- For planning individualized training events/products
  - 1-866-559-1627; DSN 642-0907

Education and Training Resources on PDHealth.mil

- Multi-Media Training Center
- Conference announcements
- Distance learning opportunities
- Events archive
- Deployment Health Library
- Condition-specific fact sheets and educational products
- Patient education and risk communication materials

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PDH-CPG Tool Kit Pocket Cards Version 1.0 December 2003

PDH-CPG Training Briefs

- Produced by DHCC
- 7 video modules from 7-12 minutes
- Developed for medical providers and support staff
- Posted on DHCC web site *www.pdhealth.mil/*

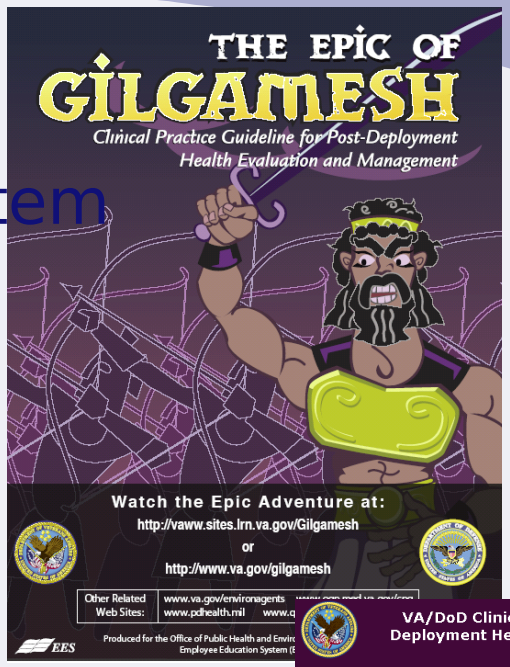
Table of Contents

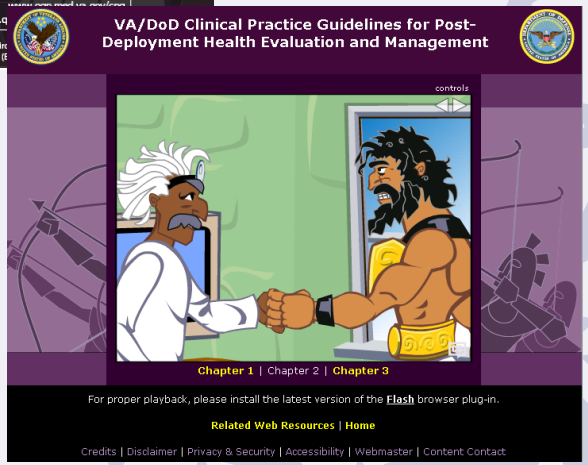
- Introduction
- Primary Care Screening
- Primary Care Evaluation
- Management & Follow-up
- Health Risk Communication
- Coding and Documentation
- PDHA

The Epic of Gilgamesh

DHCC
DEPLOYMENT HEALTH CLINICAL CENTER

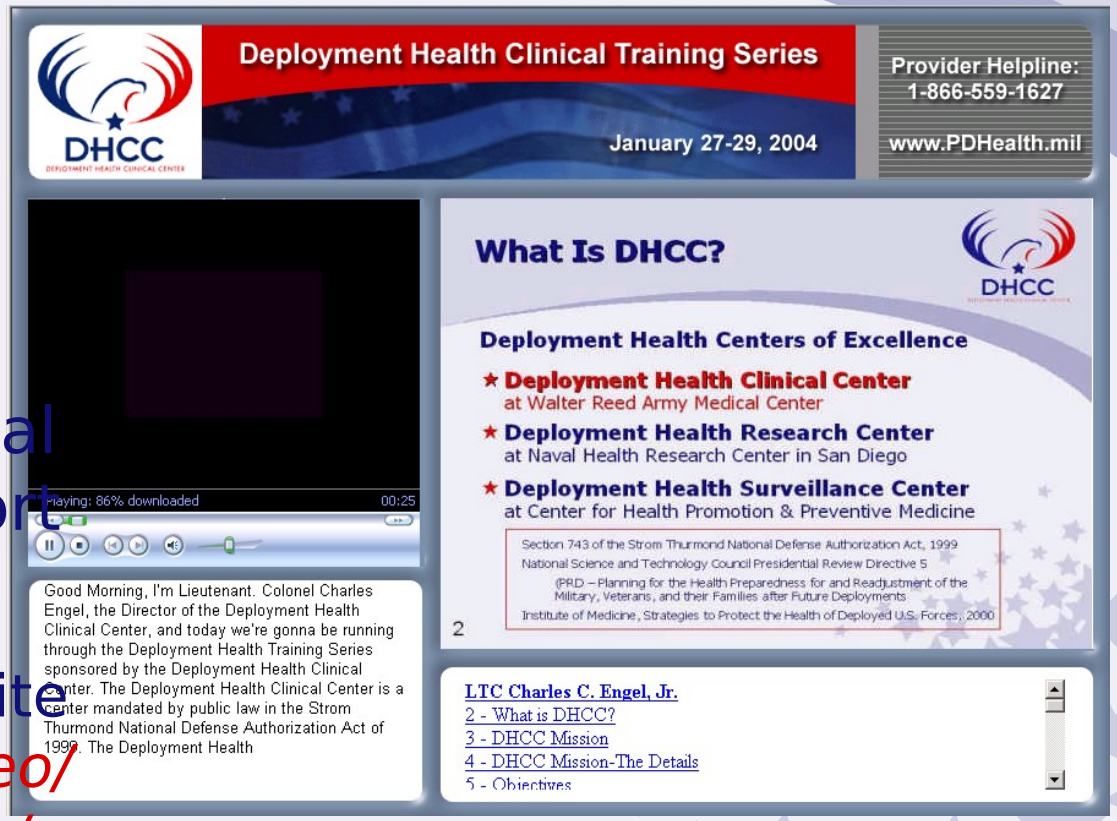
- Produced by VA Employee Education System
- 15 minute animated video of the PDH-CPG
- Suitable for providers, support staff, service members and families
- Combined with PDH-CPG Training Briefs on one CD
- Posted on DHCC web site *www.pdhealth.mil/gilgamesh/default.asp*





Deployment Health Clinical Training Series

- Produced by DHCC
- 11 modules from 17-47 minutes
- Video, script, slides
- Developed for medical providers and support staff
- Posted on DHCC web site *www.pdhealth.mil/video/clinical_training_series/dialup/index.html*



Deployment Health Clinical Training Series (cont.)

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Table of Contents

- PDH-CPG
  - Introduction/Overview
  - Screening/Evaluation
  - Management/Follow-up
  - Risk Communication
  - Coding/Documentation
  - PDHA Process
- Emerging Health Concerns
  - Suicide
  - Malaria
  - Depleted Uranium
  - Leishmaniasis

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Deployment Health Clinical Training Series

www.PDHealth.mil January 27-29, 2004

To assure the optimal viewing experience, please review the **Systems Requirement Information** before viewing the presentations listed below.

Deployment Health Clinical Training Series (41:05)
Click here to view transcription only (PDF)
Click here to view slides only (PDF)

Speaker:
LTC Charles C. Engel, Jr., MD, MPH
Director, Deployment Health Clinical Center

Deployment Health Screening and Evaluation (26:13)
Click here to view transcription only (PDF)
Click here to view slides only (PDF)

Speaker:
Mary F. Vaeth, MD, MS
Deployment Health Clinical Center

Primary Care Management and Follow-Up (20:22)
Click here to view transcription only (PDF)
Click here to view slides only (PDF)

Speaker:
LTC Patrick G. O'Malley, MD, MPH
Chief, General Internal Medicine Services
Walter Reed Army Medical Center

Clinical Risk Communication (16:45)
Click here to view transcription only (PDF)
Click here to view slides only (PDF)

Speaker:
Timothy F. O'Leary, MA

Overview of PDH-CPG Features

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- Military unique **vital sign**
- Clinically-based **risk communication**
- Use of an **algorithm-based stepped care** approach
- Emphasis on longitudinal **follow-up**
- Web-based **clinician support**
- Supporting **Center of Excellen**
- Metrics and outcomes **monitori**

Implementation Metrics

- Chart Audit
  - Documentation that beneficiary was asked if their visit was deployment-related
  - If visit was deployment-related, was (Optional) DD Form 2844 used?
  - If visit was deployment-related, was a specialty referral made? (Provider's discretion)
- Electronic Records Review
  - Ambulatory encounters for post-deployment concern were coded with ICD-9 code (V70.5_6) in ADM
- Provider Survey

Quality Metrics

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- Current Study - Army Medical Surveillance Activity
  - Electronic Records Review
    - DD 2796 referrals completed
- Future Studies - National Quality Management Program
  - TRICARE Annual Survey
    - Patient satisfaction with total care received for a post-deployment concern
  - Provider Survey
    - Adequacy of information and resources for management of patient with post-deployment concerns
  - DoD Special Study
    - Improvement in functional status within 6 months of initial evaluation

Summary
Things to Remember

DHCC
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- Remember to
  - Ask military unique vital sign to all primary care patients at every visit
  - Use appropriate codes to document post-deployment visits
  - Use risk communication techniques to build patient-provider relationship
  - Schedule follow-up visits to monitor patient outcomes
  - Refer to *www.PDHealth.mil* for deployment information and consult with DHCC as needed

Questions, Information, Assistance

DHCC
DEPLOYMENT HEALTH CLINICAL CENTER

DoD Deployment Health Clinical Cente
Walter Reed Army Medical Center
Building 2, Room 3G04
6900 Georgia Ave, NW
Washington, DC 20307-5001

202-782-6563
DSN:662

Provider Helpline
1-866-559-1627

E-mail: pdhealth@na.amedd.army.mil
Website: www.PDHealth.mil

Patient Helpline
1-800-796-9699